

**HOW DO CRIMINAL DEFENCE BARRISTERS WORK WITH
PSYCHOLOGICAL DISTRESS THROUGHOUT THE COURTROOM
PROCESS?**

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ABSTRACT

Whilst a significant proportion of those coming through the Magistrates' Court have mental health difficulties and associated social disadvantage and vulnerability, there would appear to be insufficient resources to meet their needs. Eight criminal defence barristers, who received no professional training in mental health, were interviewed about their experience of working with these clients. Thematic analysis of data, from a critical realist epistemological position, generated two themes. "Working with clients' mental health difficulties" describes how mental health is constructed, identified, and defended; the systemic issues that may compromise the defence; barristers' attempts to mitigate harm and manage distress; and finally, barristers' own distress. "Professional anxiety" captures how barristers are strained by their recognition of a flawed system; conflicting obligations to the court and their client; and pressures of poor resources, feeling very responsible, and needing to present an illusion of confidence.

A discussion of these results included consideration of the potential for a medicalising narrative to lead to legal paternalism (subjugating the client's autonomy in an attempt to act in their "best interests"); and the deprivation of defence options; possibly representing unintended human rights violations. Barristers found clients with mental health needs were particularly emotionally taxing, desired training to work with them, and suggested that these clients were vulnerable to wider discrimination and inequalities in the criminal justice system. Concerns were raised by the barristers' significant risk factors for "burnout" (a state of psychological stress), and the implications of this for both their emotional well-being, and the risk of exposing their clients to financially driven unethical behaviour. Systemic changes, informed by clinical psychology, were recommended, including training for barristers.

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DEFINITIONS

Whilst acknowledging the underlying medicalised narrative of the terminology “mental health,” this has been used interchangeably with “distress” throughout this thesis for readability.

“Barrister” is UK specific; “lawyer” has been used here to refer to equivalent roles in the US, Canada, or Australia.

“Defence strategy” is used heuristically to refer to the barristers’ legal actions, as to make continuous legal distinctions would be taxing for the reader. It is acknowledged that use of, for example, fitness to plead proceedings is a part of the plea process preceding the trial, and is therefore technically and legally not part of the defence.

ABBREVIATIONS

CJS: Criminal Justice System

MC: Magistrates' Court

NHS: National Health Service

GLOSSARY

Bar Council – the General Council of the Bar, to give it its full title, is the Bar's representative body.

Bar Standards Board – or BSB, is the Bar's regulatory body.

Barrister – a member of the Bar of England and Wales.

Call – the ceremony whereby you become a barrister.

Chambers – a group of barristers in independent practice who have joined together to share the costs of practising.

CPS – Crown Prosecution Service. Government body responsible for the prosecution of criminal offences in England and Wales.

Junior – a barrister not yet appointed silk. Note: older juniors are known as senior juniors.

Pupillage – the year of training undertaken after Bar school and before tenancy.

Adapted from Chambers Student (2014)

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DEDICATION

For Vera.

1 INTRODUCTION AND LITERATURE REVIEW

1.1 INTRODUCTION

Mental health and the criminal justice system (CJS) are inherently, and reciprocally, linked (Erickson & Erickson, 2008). A significant proportion of those coming through the CJS have mental health difficulties, and associated social disadvantage and vulnerability (Social Exclusion Unit, 2002). Historically, two competing narratives have shaped the discourse around those who are both distressed and socially deviant: medicalisation, and criminalisation; or more brutally: mad or bad? The legal context that enables criminalisation will be examined, as will the reasons why medicalisation might pose a problematic alternative. Whilst providing a background to the thesis that is important in its own right, these constructs are also proposed as potentially informing the thinking and associated defence strategies of criminal defence barristers, the focus of this research.

I will discuss systemic failures in the CJS, and how wider issues of poor training, patchy interagency working, and a dearth of adequate procedures, are paralleled within the Magistrates' Court (MC). Relevant policy, such as discriminatory practices towards vulnerable defendants, will be considered. Reform of the CJS is a current political issue: I will outline the current interest in expansion and standardisation of Liaison and Diversion schemes (Sainsbury Centre for Mental Health, 2009), which siphon defendants into the mental health system. I will suggest that this may represent a process of medicalisation, which could potentially pose a new set of problems.

Barristers have a crucial role in the MC, responsible for forming and presenting their client's defence; some of these legal processes will be outlined. Some concerning aspects of their emotional and professional context will be described, including a process of professional socialisation that may encourage the suppression of emotion, an overload of work, experiences of role conflict; and the potential for these factors to lead to the state of psychological stress labelled as "burnout". It is suggested that whilst the work is inherently demanding, the specific challenges posed by clients with mental health

difficulties, combined with a pressured and potentially discriminatory system, may result in particular strain for barristers.

Whilst suggesting the system is ill set-up to meet defendants' needs, it will be argued that barristers are equally ill-resourced to do so. The reasons for this, including poor professional guidance and a lack of mandatory training, will be explored; as will the potential implications of poorer outcomes for their clients, and harm to barristers' emotional welfare.

Finally, I will explain the relevance of this research to clinical psychology, linking to both the wellbeing of defendants and barristers, and the human rights implications of a systematic disadvantage to those with mental health difficulties.

1.1.1 SCOPE OF THE RESEARCH: EXCLUSIONS

Whilst injustices in the CJS are wide-ranging, exclusions were necessary for reasons of focus and depth within a limited piece of research. The literature review and interview questions therefore focus on "mental health," or "psychological distress." This study does not explicitly examine the experience of those with a history of neurodevelopmental disability or trauma, including learning disabilities; or substance misuse; these groups are also overrepresented within the CJS (Children's Commissioner, 2012; Hartwell, 2004; Talbot & Riley, 2007). Differentiating on diagnostic lines is problematic from a psychological perspective (Boyle, 2007), and so specific diagnostic exclusions were not made; moreover as an exploratory study, to an extent what was brought to the interviews was defined by the barristers themselves. Solicitors, who perform a similar role to barristers in this context, were also not part of the study.

1.1.2 DEFINITIONS OF TERMS USED

Whilst this research is framed as an investigation into psychological distress, constructions of distress as a "mental health difficulty" or "mental health need" within the CJS will be considered. Whilst the validity of this construct is debated, using this construct as a label can have real implications for defendants and is therefore of interest (illustratively, a psychiatric assessment that diagnoses a defendant with depression could provide mitigation for sentencing). This thesis

will refer to “mental health difficulties” or “needs” throughout as a heuristic for a group of people who experience such distress that their wellbeing or functioning is inhibited, and whom through a psychiatric lens, may be referred to as having met diagnostic criteria for so-called mental illnesses (Johnstone, 2011).

Importantly, since mental health is not routinely assessed in the MC (Khanom, Samele, & Rutherford, 2009), barristers are likely to come across many clients in great distress and who would meet such criteria, but who may never have been given a psychiatric diagnosis.

This research therefore sets out to consider how barristers work with such individuals, who may meet diagnostic criteria for a mental health difficulty, but who may or may not actually have been diagnosed. It is therefore being considered at one-step-removed, with mental health viewed through the lens of the barristers’ constructions, rather than something defined or measured in a more quantitative way. This research is furthermore concerned more loosely with “psychological distress”: that is, distress arising from the heightened emotional environment of the courtroom. How do barristers manage this distress, and given the likely lack of diagnostic labels attached to their clients, how do they differentiate it from a mental health difficulty? Furthermore, an unexpected finding of this research indicated that barristers may themselves be distressed, which will also be discussed.

Whilst the title reflects this dual understanding of distress: clients’ longstanding difficulties that could be labelled as a mental health problem, as well as both barristers’ and defendants’ more situational distress, this thesis places a far greater emphasis on understanding the former issue, reflected in the use of “mental health” throughout. The reader may question the use of such a title as opposed to something explicitly naming mental health. However, this decision has been informed by the critical realist epistemological position of the work. Titles do not afford sufficient space for deconstruction, and it was therefore decided that the use of “mental health” in such a context would be unjustifiably reifying of the construct. It was for these reasons that “psychological distress” was used instead.

Finally, “courtroom process” is used here to refer to the different stages of the trial, and considers how barristers’ ideas about mental health may influence the

legal processes at each stage. The barristers' involvement is generally very short for each client, and aside from the actual representation of the client in court, will frequently involve only a brief meeting shortly before the trial starts, unless there are complicating factors such as adjournments (Morison & Leith, 1992). The courtroom process in relation to barristers' involvement has been conceptualised as: pre-trial, during the trial, and post-trial outcomes. Pre-trial refers to barristers' prior knowledge and experience of clients with mental health difficulties, and how they construct mental health; during the trial refers to how barristers' work with their clients' distress and the specific legal actions they may take to defend these clients with mental health difficulties, and post-trial refers to how barristers make sense of the outcomes for these clients.

1.1.3 SEARCH STRATEGY

Due to the extensive breadth of the relevant literature, a narrative rather than systematic search strategy was employed. This included searching legal and psychology databases, government policies, key journals, and the references of relevant papers. In order to get the most up-to-date policy documents, professionals named on key policy documents were contacted for suggestions for further references.

Papers were considered from any time frame. Databases included: HeinOnline (on 15.10.13), EBSCO (15.10.13), Psycinfo (28.10.13), Science Direct (28.10.13), and Google Scholar (11.13.14); search terms were as wide as possible and included: ((mental health OR mental illness OR stigma OR mental disorders OR psychiatric symptoms OR personality disorders) AND (barristers OR lawyers OR attorney OR criminal defence OR court case OR magistrates OR criminal responsibility)). Searches were repeated on 20.04.15.

A review of this literature follows.

1.2 CONSTRUCTIONS OF MENTAL HEALTH

This literature review begins with some discussion of how mental health has historically been constructed within the CJS. Given the vast nature of this subject, this will necessarily be a summary, provided to orient the reader to an important context to the work. The implications for the barristers in this study will also be considered.

1.2.1 MAD OR BAD: TO MEDICALISE, OR CRIMINALISE?

Mental health is inherently, and reciprocally, linked to the CJS (Erickson & Erickson, 2008). Following deinstitutionalisation, those who had formerly been incarcerated in asylums were not adequately supported by community care. Many became homeless due to a number of factors, including a lack of or unwillingness to accept treatment, and experimentation with alcohol and drugs; and thus ended up in the CJS (Erickson & Erickson, 2008). A reduction in the hospital population has been found to correlate to a corresponding increase in the prison population (Palermo, Smith, & Liska, 1991). This has been termed the balloon effect: you push in one part of the balloon, and it will bulge out elsewhere (Palermo et al., 1991). Mental health was thus increasingly criminalised, with a shift from a treatment to a punishment paradigm, with prisons functioning as de facto asylums (Erickson & Erickson, 2008). Harcourt (2006) argues this is a continuity of confinement, with the socially deviant simply confined in jails instead of hospitals.

An alternative model of social control is to medicalise deviancy: through this lens, evil and immoral acts are instead the product of sickness. While seemingly a more humanitarian and optimistic perspective, Szasz (Ennis & Szasz, 1972) argues this depoliticises what is essentially a moral judgement; and that what is described as “good health” simply represents an adjustment to the status quo. It is beyond the scope of this thesis to examine this debate in detail, but it is worth briefly sketching some of the consequences of medicalisation, as these may be relevant to the barristers in this study.

Arguably, narratives of distress become dominated by medical authority, meaning that only professionals are empowered to discuss them (Peter & Schneider, 1992). Medicalisation provides only a partial excuse, leading to confusion and the dislocation of responsibility for deviant behaviour. This dislocated responsibility leads to the reduction in status of medicalised individuals, as the not-responsible-and-sick become dependent on the responsible-and-well (Peter & Schneider, 1992). Finally, such ambiguity about culpability jars against the clear and definite nature of the law, discussed below.

1.2.2 CONSTRUCTION OF MENTAL HEALTH WITHIN THE CJS

Psychiatric and legal constructions of mental health are so different as to essentially be opposing. The law determines blameworthiness with reference to free will, based on a philosophical tradition of moral reasoning and religious conceptions of good and evil. Guilt means a criminal act has been committed freely and deliberately; it is thus underpinned by values of punishment and retribution (Erickson & Erickson, 2008).

In tension with this, the behavioural sciences, including psychology, sit within a social world that is very differently constructed. Rather than a moral or philosophical tradition, the scientific perspective is empirical and deterministic. Since free will is not measurable, it has no explanatory value and is thus discarded; instead causal explanations are favoured based upon psychological, social, societal, and biological explanations. Rather than punishment, a medicalised perspective on the treatment of offenders is more utilitarian, based upon prevention and rehabilitation (Erickson & Erickson, 2008). A medicalised perspective on distress has gained social currency in recent years (Peter & Schneider, 1992) and has been backed by government initiatives such as the “Time to Change” campaign (Henderson et al., 2012).

Given these very different constructions, it is hardly surprising to find that mental health difficulties do not sit well within a legal framework. The law allows for the fact that those with “mental disorder” may not be fully responsible for their actions (Crown Prosecution Service, 2010), but notions of rationality, autonomy and the fluctuating nature of mental health add to a very complex construction of responsibility (Hall, Miraglia, & Li-Wen, 2011). Criminal responsibility can only be fully abdicated by use of the “insanity defence,” which is only applicable to a tiny proportion of defendants in the Crown Court¹. Whilst technically admissible at the MC, the reality for most defendants is that mental health difficulties do not constitute a defence in themselves and can only be taken into consideration as mitigation. Emotional, social and societal factors, and to a large extent contact with reality at the time of the offence, are not

¹ Approximately 30 pleaded successfully each year (The Law Commission, 2012)

considered in determining “guilt;” as these are irrelevant to the legal constructs of moral agency and reasoning.

The tension between legal and psychiatric constructions of mental health, and their underlying philosophical positions, has led to considerable and controversial debate. Whilst it is beyond the scope of this thesis to outline these debates in depth, the example of personality disorder may help to illustrate how these play out in practice. Personality disorder can be considered a mental disorder as defined by the DSM (American Psychiatric Association, 2013) and from this perspective could be used in the defence of a crime, citing reduced responsibility as a mitigating factor. Yet, personality disorder is considered to be life-long, has been claimed to be untreatable, and many if not most of the prison population may meet diagnostic criteria (Hall et al., 2001), and therefore to grant diminished responsibility to these individuals would cause severe disruption to the CJS. Furthermore as discussed earlier, to medicalise individuals by claiming they offend because they are unwell also leads to confusing questions about the nature of responsibility, and human autonomy (Peter & Schneider, 1992). Evidently, there is fertile ground for disagreement and debate when it comes to dealing with mental health within the CJS. How, then, do barristers make sense of these issues?

1.2.3 BARRISTERS’ CONSTRUCTIONS OF MENTAL HEALTH

This thesis sets out to consider the barristers’ experience of working with clients with so-called mental health difficulties. Research suggests that constructions of mental health will have a bearing on how barristers think about, and work with, their clients with mental health needs (Laberge & Morin, 1998). Barristers work within a system that criminalises deviancy, yet live in a cultural context that privileges medicalised explanations. To date, no research has attempted to understand how barristers make sense of these competing narratives; it will therefore be examined from an exploratory angle by this thesis.

Having outlined some of the historical medical and legal narratives that construct mental health within the courtroom, the introduction now moves on to consider further important contextual influences on barristers’ experience, such as the structure of the CJS and their training and professional experiences. The

issue of the construction of mental health and related debates within the CJS will, however, be returned to later in “implications for defendants with mental health needs,” so as to relate these issues more directly to the thesis topic, the barristers’ experience. Some speculation will be offered as to how barristers may think about these issues, and the possible implications for defendants.

1.3 THE CRIMINAL JUSTICE SYSTEM (CJS)

The great number of individuals with mental health needs within the CJS has been recognised but thus far poorly researched, or tackled. What attempts there have been at either will be presented, as will issues related to the current political context of the MC.

1.3.1 ORIENTATION TO THE CJS

All criminal cases begin in the MC. More serious crimes, such as murder², will proceed to the Crown court; but vast majority (95%) of cases are tried here. Some 2 million cases per year come through MCs, of which two thirds are motoring offences, with examples of the remainder including: theft, violence against the person, drug offences, and criminal damage (Department for Constitutional Affairs, 2006). As will be discussed, many MC offences might be differently conceptualised as a “symptom” of a mental health problem, for example, drug addiction; or as an understandable action in a life of social exclusion, deprivation, and consequent psychological distress. Criminal defence barristers work in both the Crown court, and the MC; they are referred to as “junior” barristers until they reach the senior position of “Queen’s Counsel”, typically only once more experienced and working in the Crown court. Consequentially, all participants in this study were junior barristers.

It is been claimed elsewhere that the MC was established, and continues to function, by eroding the due process of law: that is, replacing a trial by jury with a trial heard only by Magistrates (Winn, 1986). Instead of seeking to serve justice, it merely operates as the most efficient means of crime and social control (Winn, 1986). It will be suggested that the most vulnerable in our society are at most risk of discrimination and injustice from the MC, due to a toxic

² A defendant may also elect to be tried in the Crown Court

combination of prosecution of petty crime, a drive to process defendants as quickly as possible, and the particular pressures on defence barristers. Unlike the Crown court, mental health concerns are not routinely screened, and are much less likely to be identified (Khanom et al., 2009). For these reasons, the focus of this study is the MC, not the Crown Court.

1.3.2 NUMBERS OF DEFENDANTS WITH MENTAL HEALTH NEEDS WITHIN THE CJS

Determining exactly how many defendants have mental health needs is problematic. Mental health has historically been neglected within the CJS, which is reflected in the dearth of epidemiological mental health research in all areas of the system. Mental health is not routinely measured by the Ministry of Justice (Department of Health, 2009), and it is accordingly difficult to reach a useful estimate of the level of mental health needs. Somewhat outdated now, the most comprehensive evidence comes from a study of psychiatric morbidity in prisoners (Singleton, Meltzer, & Gatward, 1998). This indicated that over 90% of male and female prisoners met criteria for one of the five disorders studied (psychosis, neurosis, personality disorder, and drug and alcohol dependence), with over 80% meeting criteria for two or more.

Whilst there has been no research of this quality since, more recent attempts to collate information from different sections of the system suggest that a significant proportion (if not a majority) of offenders have mental health needs (Durkan, 2009). For example, a survey of newly sentenced prisoners found 10% met criteria for a psychotic disorder and 61% a personality disorder (Stewart, 2008); and there continues to be high levels of suicide and self-harm in prisons, compared to the general population (Ministry of Justice, 2015).

Moreover, to deconstruct the terminology somewhat, it could be considered somewhat disingenuous to dichotomise these issues in this way: a group with mental health needs, and a group that offend. Arguably, these labels serve to obscure shared contextual factors, such as social disadvantage and exclusion. For example, the development of difficulties diagnosed as “mental health” is associated with being a lone parent, unemployed, disability and illness, and leaving school early (Social Exclusion Unit, 2004); paralleling this, offending

behaviour is associated with high levels of family, educational, occupational, and health disadvantage (Social Exclusion Unit, 2002). Research suggests that the relationship between both mental health diagnosis and offending behaviour, and social exclusion, is reciprocal and reinforcing (Social Exclusion Unit, 2002), with individuals with mental health labels in the CJS perhaps facing a “double discrimination” (Department of Health, 2009).

As will be discussed, perhaps treating mental health difficulties in the CJS rather misses the point, with preventative work to address inequalities a more useful method of reducing distress. However, these are huge issues, beyond the remit of this thesis. It is therefore acknowledged that the isolation of mental health needs is a construction, and a somewhat problematic one at that; but the use of these labels have real-world implications for defendants in the CJS. A deprived and unhappy life offers little in the way of legal defence, whereas a mental health diagnosis can be submitted as mitigating evidence. “Mental health” is therefore used throughout from a critical realist epistemological position: a socially constructed label, but one with powerful implications for an individual’s material reality. This will be explored further in the Methods and Discussion chapters.

1.3.3 SYSTEMIC FAILURES IN THE CJS

Concerns about how people with mental health needs are treated within the CJS are serious and system-wide. An independent report was commissioned in 2013, following a number of tragic deaths in police custody (Adebowale, 2013). It found that throughout the system, vulnerable individuals are routinely met with stigma, ignorance, and a lack of resources. Mental health issues are either not acknowledged or met with discrimination, interagency working and communication is poor, and procedures to protect the vulnerable are not followed. These systemic failings have been directly linked to a number of preventable injuries and deaths (Adebowale, 2013), and it will be suggested here that defendants in the MC are likely to suffer from these issues.

This research has been written at a time of great systemic flux, with various cross-departmental initiatives considering how to better meet the needs of people with mental health difficulties within the CJS (e.g Durkan, 2009; May,

2014). It is encouraging that there is recognition of these systemic failures and a drive to completely overhaul the current system. However, such changes are in their infancy, and exist in tension with other political agendas. The current interest in diverting defendants with mental health needs away from the CJS will be presented from a critical perspective; as will concerns about safeguarding the vulnerability of these clients, and the implication for their human rights. Some current political issues in the MC will now be discussed.

1.3.4 LIAISON AND DIVERSION SCHEMES

Liaison and Diversion schemes were created in the 1980s, aiming to promote better liaison between the CJS and health services, and to “divert” more of those with mental health needs from the former to the latter (Durkan, 2009). Provision and scope substantially vary; typically there is little good-quality research to draw upon, but probably less than half of all courts England and Wales had any coverage in 2009 (Durkan, 2009). In 2010, a new “National Liaison and Diversion Development Programme,” was announced by the government, with £50 million funding and a commitment to all areas having a fully functioning service by 2017 (The Stationery Office, 2010).

Whilst almost universally regarded as a “good thing” (Offender Health Research Network, 2011, pp 15), there is very limited research into the effectiveness of Liaison and Diversion schemes. What has been published tends to focus on immediate, rather than long-term outcomes (for a review of services and outcomes, see: Offender Health Research Network, 2011). There is little examination of what constitutes a good outcome and the assumptions underlying this. Whilst some services take a psychosocial approach, e.g. increasing employment opportunities, others may run to a more medical model (Durkan, 2009). This may involve the separation of “mental illness” from the social context in which this was established. In other words, management and treatment of the so-called symptoms is sought, rather than addressing the material disadvantage and social exclusion that may have precipitated both the distress, and the criminal behaviour, in the first place.

Whilst it is of course important to ensure that distressed individuals have adequate access to services, arguably, merely increasing referrals to diversion

services may not be the tidy solution it seems. Indeed, given this group is likely to come flagged as high-risk, they potentially merely face different sanctions and coercion within a patriarchal mental health system: for example, forcibly medicated as part of a “mental health treatment requirement” (Sainsbury Centre for Mental Health, 2009). As suggested above by the theory on medicalisation, diversion services may simply reproduce the social control function of the CJS, albeit sanitised in the language of “treatment.”

The little empirical evidence available lends some support to this possibility: a one-year prospective study of referrals to a new psychiatric diversion scheme led to 60% of referrals being admitted to hospital, and accounted for 12.8% of the total sections under s37 of the Mental Health Act 1983 in England over the period of study, despite only serving a population of 500,000 (James & Harlow, 2000). Likewise, a national survey returned by 64 schemes reported that courts followed recommendations to divert to hospital, but were less likely to accept recommendations for community treatment (NACRO, 2005).

Previous research appears to assume that that increased referrals to mental health services is necessarily the best outcome for these individuals; (e.g. Covarrubias, 2008, Sainsbury Centre for Mental Health, 2009; Conduit & Heseltine, 2005). However, due to the theoretical issues of medicalisation discussed earlier, and the worrying reality of increasing coercion suggested by the figures above, this is not an assumption that I share. This research was thus undertaken from an explicitly neutral position: rather than considering how to increase referrals, it merely aims to examine how the CJS currently intersects with mental health services, and the barrister’s role in negotiating this.

1.3.5 VULNERABLE DEFENDANTS AND HUMAN RIGHTS

Defendants with mental health needs have recently been constructed as “vulnerable,” with thought given to their ability to take part in the legal process (Talbot, 2012). As will later be discussed, the vast majority of defendants with mental health needs will be deemed fit to stand trial, including those whose difficulties may well affect their ability to fully participate. For example: hearing voices, fear, or difficulties communicating may make the already stressful environment of the courtroom intolerable and potentially incomprehensible.

However, vulnerable defendants are not currently afforded the same legal rights as vulnerable witnesses, for example, the use of an intermediary to help them to understand proceedings. Whilst this has recently been recognised as unfair, and changes have been recommended (Talbot, 2012), a timeframe for implementing these legal changes has not been forthcoming. Meanwhile, vulnerable defendants continue to go through the MC, without statutory provision to help them comprehend the process.

It is difficult to overstate the implications of this. Defendants with mental health difficulties are protected by the Equality Act (2010) under which the courts have a duty to eliminate unlawful discrimination on the basis of disability, and promote equality. By not providing protection for these clients, they are arguably suffering institutional discrimination. Moreover, the defendant's ability to effectively participate in court proceedings, and to have a fair trial, may be compromised. This is protected by Article 6 of the European Convention on Human Rights (1950). Clients with mental health needs in the MC are therefore at risk of institutional discrimination, and a violation of their human rights, by virtue of an inability to comprehend and participate in their trial.

1.3.6 POLITICAL CONTEXT OF THE MAGISTRATES' COURT

Yet as a parallel process to the political rhetoric of reform, diversion, and investment, MCs have become ever-more target driven, focussed on "processing" defendants rather than, arguably, giving them a fair trial (Hungerford-Welch, 2010). Under this agenda, the priority is to decrease cost by increased processing speed, aiming for an increase in guilty pleas, and a reduction in both the quantity and time length of hearings (Department for Constitutional Affairs, 2006)

The current context of the MC is therefore incredibly pressurised, and likely to be at odds with the needs of those with mental health difficulties. As discussed later, there are a number of legal processes that allow mental health to be taken into account; almost all of which are likely to delay proceedings, and potentially create resistance from the Court. There is evidence to suggest that courtroom professionals have internalised this agenda and consider delivering "simple speedy summary justice" their priority, with consideration of mental health

needs an interference in this process (Khanom et al., 2009). Defendants with mental health difficulties may face the double jeopardy of having both “offended,” and holding a stigmatised diagnostic label (Department of Health, 2009). Due to Magistrates’ “fused powers,” negotiation of adjournments and other measures may necessitate a disclosure of mental health difficulties to the court, regardless of whether or not this forms part of the defence, thereby potentially biasing the case.

Thus, whilst there is currently an important and substantive move to decriminalise defendants with mental health needs, afford them equal rights so that they can effectively partake in the CJS, and liaise better with NHS mental health services; these changes are in their infancy, and in opposition to other pressures on MCs. How, then, do barristers negotiate these systems when working with clients with mental health needs?

1.4 THE COURTROOM PROCESS

To answer this question, we return to the research question and begin to consider the courtroom process as it relates to barristers. For the purpose of this thesis, the courtroom process has been conceptualised chronologically, as relating to pre-trial, during the trial, and outcomes of the trial. The following literature therefore reviews the emotional and professional context that barristers may bring to the trial and the potential ways they may construct mental health, the actions that they may take during the trial, and considers potential implications of these factors on the outcomes for defendants. The reader should note that the following subsections are, however, ordered for readability rather than reflecting this chronological conceptualisation.

1.4.1 LEGAL CONTEXT

Criminal defence barristers, referred to simply as “barristers” for readability, are responsible for advocating on behalf of their clients in the MC. Thus they occupy a pivotal role for their client, in both preparing their defence, and as the advocate who will stand alongside them during their day in court (Elliott & Quinn, 2013).

The interplay between the law and mental health, and the barrister’s role in negotiating this, is hugely complex; comprehensively detailing this legal process

is beyond the remit of this thesis. However, a sense of barristers' legal opportunities and responsibilities is useful context to the research. Table 2 provides an overview of potential legal processes in the MC that specifically relate to mental health, and barristers' associated responsibilities for these. Besides the very limited application of the insanity defence described earlier, mental health can be considered in relation to: the prosecution pre-trial, fitness to plead, occasionally used as a defence in its own right, and submitted as mitigating evidence for the defence. Details of these processes are provided in the table.

Table 2: Legal processes in the Magistrates' Court that relate to mental health, and barristers' associated responsibilities

Stage of process	Specific legal process re: mental health	Possible outcomes	Barristers' responsibilities
Pre-trial	The Crown Prosecution Service decides whether to pursue a case by (i) considering whether there is sufficient evidence; and (ii) weighing up where the public interest lies, including considering the client's mental health	Either the matter proceeds to trial or is discontinued by the CPS	<ul style="list-style-type: none"> - Receive pre-trial information - Contact / negotiate with the CPS to advocate that the case is discontinued on public interest grounds
Receive instructions from the client			<ul style="list-style-type: none"> - Consider client's case - Decide whether there is any question of the client being unfit to plead - Advise client regarding likelihood of acquittal / credit given for an early guilty plea - Take instructions: whether client wishes to plead guilty or not guilty - Discuss client's mental health needs, where appropriate - Advise on whether to choose trial by magistrate or jury, where appropriate

Stage of process	Specific legal process re: mental health	Possible outcomes	Barristers' responsibilities
Enter a plea (plea before venue)		A not guilty plea is entered: the case will proceed to trial in the Magistrates Court (or be transferred to the Crown Court for more serious offences or where the Defendant chooses to be tried by a jury)	- Entering the plea or otherwise as below:
		A guilty plea is entered: the case will go to sentencing	
	Ask for an adjournment to allow further time to, for example, receive further instructions / request a psychiatric assessment etc.	The Magistrates can decide whether or not to grant this	- Advocate this for the client, with or without the disclosure of mental health needs to the court.
	Fitness to Plead: the client could be assessed for capacity to understand the trial, by a healthcare professional such as a doctor	The client could be found unfit to plead. The trial then rests on whether the client "did the act" (a lesser burden of proof); if so, they may then be sentenced to a hospital	- If no previous professional has done so (e.g. solicitor), the barrister must first notice there is a problem - Arrange for a medical assessment
	Request report from mental health professional (including psychiatric report)	The trial could be stopped and the client instead referred onto services or hospital; the recommendations could also be taken into account when sentencing	- Request report (from e.g. the local liaison and diversion scheme, or a psychiatric assessment if this is not available).

Stage of process	Specific legal process re: mental health	Possible outcomes	Barristers' responsibilities
Enter a plea (plea before venue)	Referral to Liaison and Diversion Schemes	Where available, these can divert clients from the trial process to mental health services. This includes use of compulsory Hospital Orders under the Mental Health Act 1983. Assessments can be taken into account when sentencing	- Refer the client (N.B. barristers are not exclusively responsible for this, but arguably could do so if other professional groups have not: see section on Liaison and Diversion Schemes above).
	Otherwise introduce mental health as a mitigating factor for sentencing	In addition to the specific actions above, barristers can present mental health needs as mitigating factors when sentencing, potentially leading to a more lenient, or treatment-focussed outcome (e.g. Mental Health Treatment Requirement community order).	- Whilst the defendant's mental health will be routinely assessed by probation at the point of sentencing, the barrister can also advocate for this to be taken into account.

Information adapted from: Crown Prosecution Service (2010), Morison & Leith (1992), Rethink Mental Illness (2012) and Rethink Mental Illness (2013).³

³ N.B. this table is intended as a guide to the various decision points made by barristers, and potential opportunities and failures to take mental health needs into account. Therefore whilst the illustrative outcomes are accurate, the exact legal mechanisms have been simplified.

If convicted, barristers may be responsible for submitting any mental health needs in mitigation. Other responsibilities relate to the process of the trial itself, such as giving advice (discussed later), requesting psychiatric reports, referring to liaison and diversion schemes, and negotiating adjournments. As stated, due to the limitations of a thesis that must remain clinically-oriented, the above cannot be considered in depth. Dropping the case on public interest grounds, and fitness to plead proceedings are, however, particularly relevant to this research. These actions are briefly outlined below.

Theoretically, barristers can ask the prosecution to drop a case on public interest grounds, meaning that it will never come to court. In practice, however, very few cases are dropped by the CPS; for example in 2011-12, only 2.3% of post-charge decisions were made to drop cases on public interest grounds (Sosa, 2012). .

Whilst there is a two stage statutory process in the Crown Court for considering the fitness of a defendant to plead, there is no equivalent in the MC. If a defendant is suffering a treatable mental disorder [sic] (as defined by S.1 of the Mental Health Act) then, having found that a defendant committed the act or omission charged with, the Magistrates can impose a hospital or guardianship order instead of a criminal penalty. This is generally considered to be a poor outcome for everyone. A lesser burden of proof is required to convict the defendant (as the prosecution does not have to prove intent), and whilst the defendant may be acquitted, they also risk an indeterminate hospital order. Furthermore, victims are potentially deprived of an admittance of guilt and a normal conviction, and defendants are deprived of a fair chance to participate in their trial (Law Commission, 2013). If the defendant does not meet this criteria, barristers can apply for a stay of proceedings on the basis that the defendant is unable to participate effectively and cannot therefore have a fair trial; but there is no guarantee that this will be accepted.

1.5 BARRISTERS' EMOTIONAL AND PROFESSIONAL CONTEXT

Arguably then, to provide the most rigorous defence, Barristers have to consider mental health needs throughout the entire courtroom process. Having outlined some of the legal context, the emotional and professional context will be

discussed, followed by a consideration of potential implications of these issues on clients with mental health needs.

1.5.1 PROFESSIONAL SOCIALISATION

Barristers are members of “the Bar:” an arcane world, reflected in its many shibboleths (necessarily explained here only briefly: see glossary of terms). An exceptionally competitive career path, candidates must complete both an undergraduate degree in Law (or first degree and specified conversion course), and a one-year practitioner training course before being “called to the Bar.” They then must apply for “pupillage,” a one-year apprenticeship; before finally attempting to get tenancy in a Chambers, without which it can be financially difficult to practice (Harris, 2002). To illustrate the degree of competition, in 2011 there were 3017 applicants for the practitioner training course, but only 197 people achieved a place in Chambers, a proportion of 0.07% (BPTC (Bar Professional Training Council), 2012). Pupillage, leading up to an application for tenancy in Chambers, is therefore a time of low status and uncertainty, and is characterised by feelings of anxiety, shame, and distress; with the start of tenancy also experienced as frightening (Rogers, 2014). Having completed pupillage and gained tenancy, barristers will begin their career with the lower-status cases of the MC; only later progressing to bigger cases at the Crown Court (Morison & Leith, 1992).

Whilst Australian and U.S. lawyers have been a focus of psychological research, little exists on UK barristers⁴. However, the Bar’s esoteric practices have been of some interest to sociology, and the discipline’s research in this area offers a helpful perspective on the contextual influences on barristers. “Professional socialisation” refers to a developmental process; whereby individuals acquire the knowledge, skills, and sense of occupational identity characteristic of a profession; and internalise the values and norms of that group (Howkins & Ewens, 1999). It involves learning the unwritten rules and professional expectations (Harris, 2002). For barristers, this is a protracted process that spans several years, and is intensified by the hermetic nature of

⁴ One hesitates to be conclusive, but after extensive searching, I have found precisely zero psychological research involving UK barristers

the discipline. To illustrate, a minimum number of meals must have been eaten at one of the four Inns of Court for a barrister to be “called to the Bar,” and the process itself involves a formal and arcane ceremony (Harris, 2002). Collective norms are expressed overtly (e.g. interactions within the community) and symbolically (e.g. wearing the wig and gown; Whelan, 2001).

By virtue of the complexity of the work, professional codes cannot provide barristers with definitive answers; instead, instinctive and intuitive judgement is valued. Professionalism is therefore seen as a means of holding collective responsibility for these decisions, ostensibly to empower barristers (Whelan, 2001). However, one definition suggests socialisation is complete when other members of the group, observing the newcomer, would deem them competent (Howkins & Ewens, 1999). This is particularly pertinent to the insular world of the Bar, where progression is dependent upon the approval of peers (Whelan, 2001); and thus, observably conforming is necessary for occupational success. Arguably, professional socialisation therefore represents a (successful) attempt by the gatekeepers of the profession to retain power and influence, and operates as a means of exerting control over the future behaviour of its members (Harris, 2002).

1.5.2 EMOTIONAL LABOUR

One consequence of professional socialisation that is relevant for this thesis, is that of emotional labour. Originally described in research with waitressing staff, it refers to the management of emotional displays that are necessary to perform a work role (Paules, 1991). These form part of the professional expectations, and are incorporated into the occupational socialisation and acculturation; which as described above, significantly influence barristers’ behaviour. Whilst feigning emotions in court is sometimes necessary, the primary burden on barristers is the need to suppress genuine emotions (Harris, 2002), such as distress or sadness; with admitting stress not the “done thing” at the bar (Harris 2002, pp 573). There is pressure to suppress emotions not only in front of clients and the court, but also pertinently, in front of peers. This pressure can be understood in relation to professional views on emotion: that detachment from emotional states is equated to rationality, and that furthermore, suppressing emotion is an inherent aspect of professionalism (Harris, 2002).

Barristers may also feel pressured to suppress unconfident or hesitant feelings. This is of particular relevance to the junior barristers interviewed for this thesis, who necessarily lack experience when they begin working at the MC. Whilst professionally, barristers are obligated not to take on any work that “he [sic] knows or ought to know he is no competent to handle,” (Bar Standards Board, 2013, pp 27), the professional context of fierce competition and constant assessment does not encourage such admittances of incompetence. Instead, barristers completing pupillage found that:

““Self confidence out of proportion to your role” was expected.”

(Rogers 2014, pp 41)

Indeed, in order to refuse a client, one must admit to being “professionally embarrassed”:

“A barrister must not accept any instructions if to do so would cause him to be professionally embarrassed and for this purpose a barrister will be professionally embarrassed:

if he lacks sufficient experience or competence to handle the matter.”

(Bar Standards Board, 2013a, pp 27)

In summary, it is therefore argued that there is a powerful professional context influencing barristers’ working lives, which leads to the suppression of the display of negative, or unconfident, emotions. The psychological implications of this are threefold. First, suppression has direct effects on health, with for example thought suppression being shown to have acute effects on the immune system (Petrie, Booth, & Pennebaker, 1998). Secondly, suppression is linked to emotional exhaustion (Harris, 2002). Thirdly, it prevents barristers from accessing social support within their community. Both of these latter points are associated with burnout, a state of psychological stress. Before describing burnout, two other risk factors will be discussed: role overload and role conflict.

1.5.3 ROLE OVERLOAD

Barristers are likely to experience role overload, where the demands of an occupational role exceed the employee’s perceived ability to meet it (Gomme &

Hall, 1995). Criminal barristers report an average of 55 working hours a week, which is likely to underestimate the workload of junior barristers in the MC, who will typically have many more cases than those in the Crown Court; they also take the least holiday of any other faction of the legal profession (Bar Standards Board, 2013b). These long working hours are independently associated with burnout in lawyers (Bergin & Jimmieson, 2013).

Whilst already working long hours, barristers then have to find a way to work with the considerable proportion of defendants who have mental health difficulties. As discussed above, the expectation of learning on the job, and appearing confident, leaves barristers with little choice but to accept these clients. Yet it is entirely possible they feel poorly resourced for this work, as mental health training for barristers is currently neither required nor provided (Bar Standards Board, 2013a). Neither are professional guidelines offered on how best to defend these clients. This is despite the fact that, worryingly, they are often the first professional within the justice system to identify a mental health concern (Magill & Rivers, 2010). Insufficient training was raised as a concern by barristers in a piece of qualitative research on fitness to plead (a specific legal procedure related to mental health); they suggested that in order to properly advise and represent their clients, improved mental health awareness was needed (Rogers, Blackwood, Farnham, Pickup, & Watts, 2009).

Whilst training has been recommended by the Advocacy Training Council (2011, pp 48), the Fair Access to Justice Report (Talbot, 2012), and an independent review of criminal advocacy (Jeffrey, 2014); political and professional will to implement these recommendations remains unclear. The Bar Council has neither introduced a regulatory requirement, nor co-ordinated training (Cooper, 2011); and a review of the Bradley Report does not mention defence counsel at all, less still make any recommendations for their training or practice (Durkan, Saunders, & Hazard, 2014).

As discussed, vulnerable defendants do not have the same legal recourse to special measures as vulnerable witnesses, and may therefore struggle to fully participate in their trial. Research suggests that barristers feel a strong sense of responsibility to help their clients understand proceedings, and consider this

part of their role (Barry, 2010); yet without training, and within the incredibly time pressured environment of the MC, they may struggle to meet these needs.

Finally, due to insufficient training and social support, barristers may lack the emotional resources to meet the needs of distressed clients. Whilst the courtroom process is stressful for most participants, it may be particularly aversive for those who already struggle to manage their emotions, such as those with mental health difficulties (Durkan, 2009). Furthermore, barristers may need to discuss traumatic events (e.g. domestic violence), or review disturbing evidence, as part of their role in presenting the defence. Considerable research suggests this places lawyers at risk of secondary trauma, and some may go on to develop experiences such as sleeplessness, anxiety, or detachment (Fischman, 2008, Levin & Greisberg, 2003, Levin et al., 2012), although thus far this has primarily been researched in Australia and America.

A further aspect of role overload for barristers, then, is attempting to meet the particular needs of their clients with mental difficulties, despite lacking the resources to do so. Role overload, particularly where the demands are emotional, is predictive of burnout; a second risk factor, role conflict, is described below.

1.5.4 ROLE CONFLICT

Barristers are confronted with a number of impossible dilemmas: responsible for helping their clients to understand their trial, yet ill resourced to do so; aware of recourse to specific mental health defence strategies, but also aware of their limitations and risk of harm. They have:

“an overriding duty to the Court to act with independence in the interests of justice: he must assist the Court in the administration of justice and must not deceive or knowingly or recklessly mislead the Court.”

(Bar Standards Board, 2013b (302))

Yet must,

“...promote and protect fearlessly and by all proper and lawful means the lay client’s best interests and do so without regard to his own interests or to any consequences to himself or to any other person.”

(Bar Standards Board, 2013b (303))

They thus have two irreconcilable duties: to the court, but also to the best interests of their client. Things appear little progressed from the 1970s:

“In a case where the accused is or may be suffering from mental illness, however, a new range of ethical dilemmas arises – problems for which there may be no solutions, problems involving such unacceptable alternatives that it is inappropriate and unfair to force the defence attorney to choose among them.”

(Chernoff & Schaffer, 1971 pp 505)

Burnout is associated with such conflicts in values, where workers are compelled to work in a way that feels unethical (Maslach, 2003). There is little research on how barristers manage these dilemmas. One Canadian qualitative study found a typology of lawyers' defence strategies, leading to the maximisation of one component of their work, to the neglect of the others. For example, aiming to process clients as quickly as possible through the courts, but to the detriment of their defence (Laberge & Morin, 2001); the emotional repercussions of these choices were not explored. Where unaddressed, role overload and conflict can lead to role strain, discussed below.

1.5.5 CHRONIC OVER DEMAND AND ROLE STRAIN

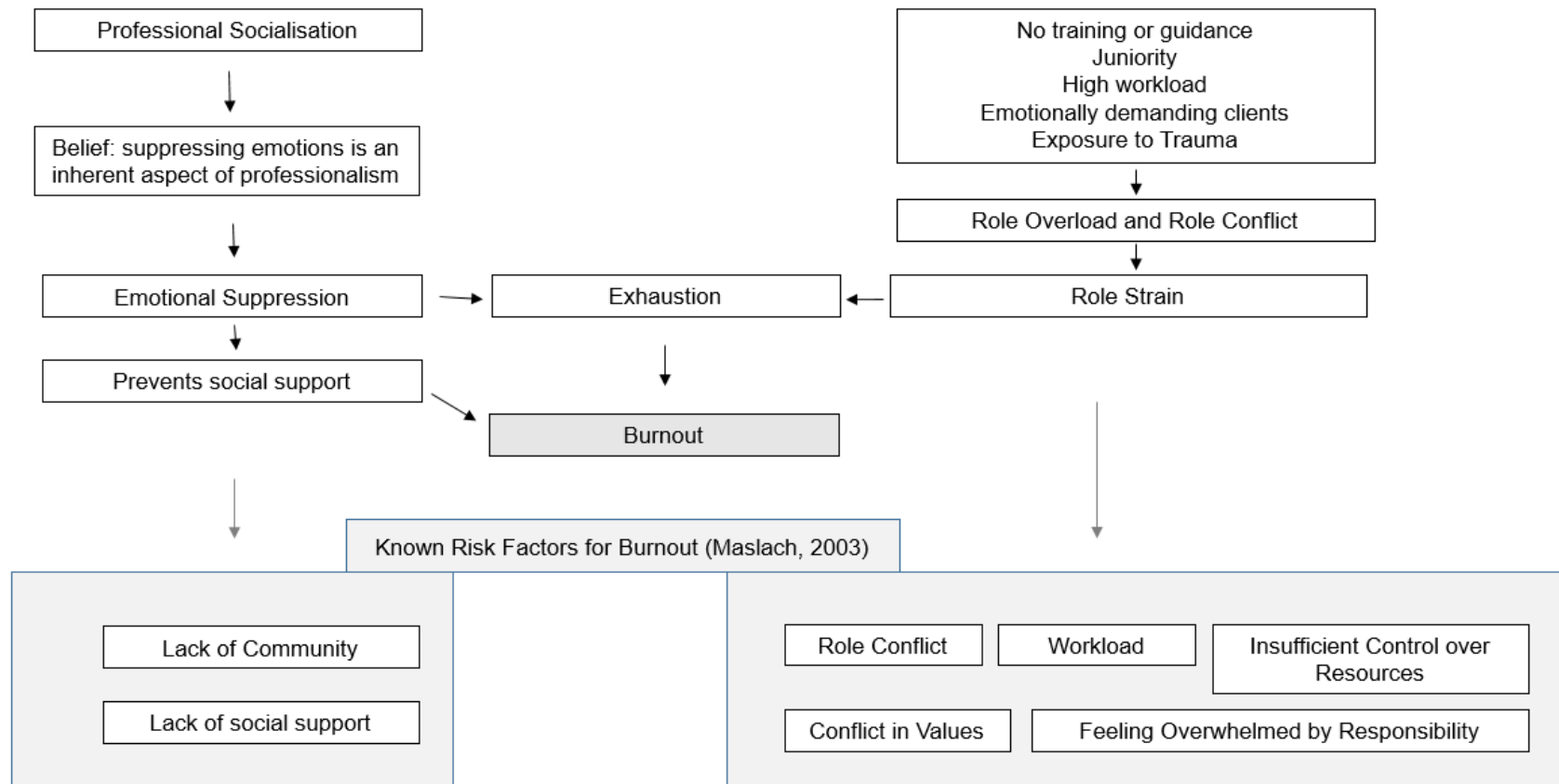
An occupational model of stress, the job demands and resources model, proposes that when job demands are chronically high, and resources are low, the result is role strain (Bergin & Jimmieson, 2013). Role strain leads to exhaustion, which in its turn, leads to burnout. Barristers are already at risk of burnout (e.g. Bergin & Jimmieson, 2013) but it is suggested here that working with clients with mental health needs, without training or support, puts them at increased risk. Burnout, and its potential consequences for both barristers and their clients, will now be described.

1.5.6 BURNOUT

Burnout is a form of psychological stress. It has been conceptualised as emotional exhaustion, a sense of inner emptiness or depersonalisation, and a lowering of personal accountability and motivation (Maslach, 2003). It can lead

to a number of unpleasant experiences, such as fatigue, hopelessness, anxiety, and aggression (Farber & Heifetz, 1982). Barristers appear to directly map of onto all the risk factors for burnout. As discussed above, these include: high workload, role conflict or a conflict in values; and a lack of social support or a loss of community (Maslach, 2003). The remaining risk factors for burnout are insufficient control over resources, arguably the case for untrained barristers in the pressured MC; and feeling overwhelmed by responsibility, potentially likely for barristers who are working with vulnerable clients (Maslach, 2003). The combination of risk factors and mechanisms described above is presented schematically in Figure 1, on the next page.

Figure 1: Schematic Representation of Proposed Risk Factors for Burnout in Barristers



Neither burnout nor the associated risk factors have been studied in UK barristers, and the above is conjecture at this stage. However, equivalent research in Australia and America indicates a concerning level of psychological distress. Lawyers working with domestic violence and incest cases have been found to experience demoralisation, anxiety, and hopelessness, which was linked to high caseloads and long hours (Gomme & Hall, 1995). Defence lawyers working with clients involved with trauma were found to be at a high risk of secondary trauma, burnout, depression, and functional impairment (Levin et al., 2011). Lawyers experience higher levels of secondary trauma and burnout than healthcare workers (Levin & Greisberg, 2003). Whilst UK barristers may have a different experience, it has been suggested here that the particular professional context of the Bar, if anything, puts them at increased risk of psychological harm⁵.

It has been argued that barristers' emotional health is significantly risked by their professional context, particularly when working with clients with mental health needs. Such psychological stress is inherently damaging and often lead professionals to leave quit their jobs (Maslach, 2003). There may also be implications for the clients they represent, discussed below.

1.6 IMPLICATIONS FOR DEFENDANTS WITH MENTAL HEALTH NEEDS

If barristers do not feel resourced to manage clients with mental health difficulties, what are the implications for their clients throughout the courtroom process? If barristers are indeed suffering from burnout, considerable research suggests that this will reduce their ability to perform their job well; for example, leading to impaired decision making (Maslach et al., 2001). Even if they are emotionally well, however, their poor training and resources may have significant implications for their clients. These will be discussed in terms of difficulties identifying mental health, and barristers' chosen defence strategy; and related to barristers' social status as highly powerful individuals.

⁵ N.B. The Bar (and professional context outlined earlier) is UK specific.

1.6.1 POWER AND JOINT DECISION-MAKING

Barristers consult with their clients about how to plead and the evidence the client wishes to present, negotiating a shared plan for the defence presented in court. This can be conceptualised as a process of joint decision making. Models of joint decision-making suggest that the partner with the most power will be the most influential in the decisional outcome (Simpson, Griskevicius, & Rothman, 2012). It is therefore of interest to consider the power dynamics within the barrister-client relationship.

Barristers form an elite group, holding one of the most powerful positions in society (Rogers, 2014), regarded as the most and fourth most prestigious career for men and women respectively (Bottero, 2005). Defendants in the CJS, however, are likely to have a history of social exclusion, with offending behaviour linked to factors including poor education, unemployment, and compromised family networks (Social Exclusion Unit, 2002); and as discussed throughout, high levels of mental health needs. In addition to the likelihood of holding the most social and material power in their advisory relationship with their client, barristers are also conferred expert power (French & Raven, 1960) by virtue of their professional training in law. Barristers are therefore likely to hold the power in this relationship, supported by evidence that that clients typically assume a trusting and passive role in relation to a barrister, accepting advice without question (Rosenthal, 1974).

1.6.2 IMPLICATIONS FOR THE IDENTIFICATION OF MENTAL HEALTH

Barristers' power thereby grants them the authority to define the parameters of the client interview, including whether mental health needs are discussed. This is pertinent as mental health disclosures are context dependent, and if barristers do not explicitly invite such disclosures, mental health needs might not otherwise be identified. Yet their lack of training may compromise this, with failings by defence counsel linked to: a lack of understanding and training in how to identify a mental health difficulty, not utilising relevant experts (e.g. psychologists), and not raising the issue of mental health in the first place (Covarrubias, 2008). The Bradley Report (Department of Health, 2009) interviewed service users about solicitors, who occupy a similar role in court to

barristers in this context; and found their lack of training potentially resulted in missed opportunities for diversion from the CJS. In a small qualitative study, this concern was echoed by barristers themselves, who wondered if they missed clients' needs due to poor mental health training and awareness (Rogers et al., 2009).

The sole piece of quantitative research found in this literature search lends tentative support to this idea: mental health difficulties were found to be under-identified in American defendants, relative to both the general population, and estimates of the criminal population; and that those with disclosed mental health difficulties had poorer outcomes than those without; concluding that mentally ill [sic] defendants were harmed by the defence attorneys' lack of training and skills (Gormley, 2013).

There are significant limitations with this piece of research, as it is somewhat tenuous to suggest that responsibility for these poorer outcomes lie solely with the defence attorneys when no other factors were controlled for. However, research with UK police broadly supports the idea that poor training in mental health may lead to under identification of mental health (Adebowale, 2013). Their similarly inadequate training and professional guidance on mental health is associated with a lack of confidence in their own judgements, resulting in potentially poorer decision-making (Adebowale, 2013). Paradoxically, whilst barristers hold a powerful position in relation to their client, a lack of training and guidance may lead them to feel disempowered to discuss mental health.

Why is this important? Mental health needs can only be considered if they are known. Yet, they are not routinely assessed in court (Khanom et al., 2009) and are often missed (Magill & Rivers, 2010). Therefore, barristers' willingness and ability to discuss mental health needs with their clients may have a direct impact upon their defence strategy, and the potential outcome for their clients⁶.

1.6.3 PATERNALISM

⁶ The reader is referred to pg. 12 and Appendix A to understand how mental health can be used as a defence

It is also troubling to consider that the imbalance of power described above may threaten the client's autonomy. Legal paternalism, whereby the client's wishes are superseded by the barristers wish to prevent harm, is well documented⁷; and may be particularly prevalent for those with mental health needs, due to the implications of medicalising distress discussed earlier (Luban, 2005)⁸. Whilst running contrary to their responsibility to act on instructions, barristers may feel a greater responsibility for their client's safety, and privilege this accordingly. Research lends some support to this idea, with one UK study finding that some barristers adopt an uncompromisingly persuasive approach to their advice, attempting to align the client's plea with the barrister's conceptualisation of their best interests (Barry, 2010). The author notes that this:

*"may undermine an essential tenant of common law jurisdictions: that the plea entered by a defendant... is informed and **voluntary**."*

(Barry, 2010, pp 120, emphasis added)

Furthermore, one study of Canadian attorneys' experiences of working with clients with mental health difficulties, suggested that some used the trial process as a proxy for community care, acting as a social worker with the primary aim of obtaining treatment for their clients (Laberge & Morin, 2001). A majority of participants said that they would not defend these clients as aggressively as they would another client. Whilst attempting to act on best interests, this paternalism threatened their clients' autonomy to make decisions (Luban, 2005). Moreover, it potentially exposed them to restrictive treatment that they had not requested. Barristers may thereby inadvertently compromise their clients' human rights.

Finally, in the study mentioned above, lawyers perceived clients with mental health difficulties to be more difficult and unreliable, with some suggesting they were responsible for both their mental health issues and their associated crimes (Laberge & Morin, 1998). Their formulation of distress and notions of blameworthiness thereby had a direct influence on their defence strategy,

⁷ For a striking example, see the story of the Unabomber, whose lawyers attempted to run a mental health defence without his consent (Associated Press, 1999)

leading to the next item of interest for this research: barristers' constructions of distress.

1.6.4 CONSTRUCTIONS AND EXPLANATIONS OF PSYCHOLOGICAL DISTRESS AND DEVIANCY

As outlined above, poorer outcomes for clients with mental health needs may be mediated by barristers' constructions of mental health; therefore this research will therefore attempt to explore how barristers construct and explain distress in the context of offending behaviour (described here as "deviancy").

Barristers are exposed to competing narratives. As they lack professional guidance and training, it may be that barristers draw their ideas about distress from the context of the courtroom. Historically, psychiatry has been significantly more involved in the courts than psychology (Leslie, Young, Valentine, & Gudjonsson, 2007); both reflecting and reinforcing the dominance of a medical model of psychological distress in the legal system (Gerard, 1986). Legal guidance on mental health uses the terminology "mental disorder" (Crown Prosecution Service, 2010). Whilst prosecutors consider clients with a diagnosis of post-traumatic stress disorder less criminally culpable and empathise with them more (Wilson et al., 2011), there is no research on whether this extends to barristers, or other forms of psychological distress.

Furthermore, the most frequent diagnosis of those in the CJS is personality disorder (Fazel & Danesh, 2002). This is arguably less well-recognised by the general public as an "illness," and psychiatry has historically dichotomised such individuals as "bad" rather than "mad" (Hall et al., 2011). Empirical research is lacking in this area; one study suggested legal professionals may view a personality disorder diagnosis as not meeting a mental health treatment threshold, but this was not explored in depth (Khanom et al., 2009). Blame and culpability has been found to be associated with type of diagnosis in research with jurors, with those deemed more responsible for the onset of their "illness" viewed more negatively (Fenwick, 2011); it may therefore be that barristers may also consider clients with a label of personality disorder are somehow less deserving, or more responsible for their actions.

Thus, barristers may be influenced by a medical model that considers defendants to be “mad,” or potentially, for certain clients, they may consider them fully culpable and consider them to be merely be “bad” (a criminalising narrative). Considering their role is to defend their client, adopting this latter conceptualisation would seem somewhat surprising. However, as described earlier, some Canadian lawyers’ discourse did appear to reflect a criminal justice ideology, feeling that their clients were responsible, and needing to be punished and taught the consequences for their actions (Laberge & Morin, 1998).

Finally, an alternative model of deviancy might be provided by a psychological or social model, which relates offending behaviour to environmental causes. Whilst one study suggested lawyers preferred psychiatrists to psychologists, finding psychological formulation considerably more complex, jargon-filled, and less useful than psychiatric diagnoses (Leslie et al., 2007); this was in the context of gaining reports for use in the courtroom. It may therefore reflect their views on the utility of such reports as evidence, rather than their personal views. There is no research on this to date, and as lay people tend to prefer psychosocial explanations of distress over medical diagnoses (Jorm, 2000), it is fair to consider that this may also be a narrative reflected by the barristers.

1.6.5 STIGMA

Finally, some thoughts on stigma. One legal paper suggested that peoples lived experience of stigma would induce them to “mask” their mental health difficulties, thereby reducing the barrister’s chance of identifying these (Covarrubias, 2008). Barristers may therefore need to work hard to quickly form a trusting relationship with a client, and explicitly welcome disclosure of mental health difficulties, or they may not be expressed. It is has been suggested that barristers own stigmatised attitudes may impede this conversation (Covarrubias, 2008). This is a reasonable assumption, given the prevalence of stigma (Hinshaw, 2007); there is no reason to think that barristers should be immune from these wider societal influences. Indeed, research within the CJS with police officers has found poor training in mental health is associated with fear, stigma, and discriminatory practices; this may extrapolate to barristers (Adebowale, 2013). The potential for stigmatised attitudes will therefore be

considered from a position of curiosity, aiming to neutrally explore these if identified.

1.7 SUMMARY

A significant proportion of defendants in the MC will have some degree of mental health difficulty. Historically, however, the CJS has neglected their needs, resulting in systematic disadvantage to these clients, perhaps even compromising their human rights. Whilst the government has acknowledged these failures and proposes a radical overhaul, at present there is little change on the ground, and a parallel process of cost-cutting that threatens to undermine any positive changes. Defendants therefore enter into an immensely pressured system.

These systemic pressures have to be negotiated by the defendant's legal representative: their barrister. Barristers play a crucial role in the courtroom process, constructing and negotiating a defence for their clients. They are hugely powerful agents, particularly as part of a dyad with a likely materially and socially disadvantaged client. Lacking training or professional guidance; and exposed to competing narratives of both the criminalising legal context, and the medicalised discourse of mental health; it is unclear how their constructions of distress might influence their identification and defence of mental health. Whilst mental health difficulties rarely constitute a defence in its own right, a diagnosis can otherwise be used tactically (e.g. fighting for the prosecution to drop the case). It has been suggested that there is a risk of legal paternalism, where barristers act on presumed best interests rather than collaboratively; equally, if they do not feel confident to discuss mental health, their client may be deprived of defence options.

Having reviewed the limited available literature on barristers, it seems that as a group they are at risk of burnout, a state of psychological stress; but that moreover, they may be particularly taxed emotionally when working with clients with mental health difficulties. Barristers may end up fulfilling roles outside of their ostensible job description, as their clients' needs will not otherwise be met by the CJS. Yet, they are ill resourced to do so, by an exceptionally high workload and pressured working environment, conflicts in role with no

acceptable resolution, a professional context that promotes emotional suppression rather than support-seeking, and a total dearth of training in mental health. Barristers' emotional health may thereby be damaged, as might their ability to defend their clients.

1.8 QUESTIONS ARISING FROM THE LITERATURE SEARCH

Since there is a poverty of research that explicitly addresses barristers and mental health, a number of questions relevant to clinical psychology are apparent from the literature search. Barristers face pressure from a likely very stressful working environment, and are not trained in mental health. They perhaps may not feel resourced to meet their clients' mental health needs, so what is it like for them to work with these clients? Without training and exposed to competing narratives of distress, how do they construct mental health? Does the way they construct mental health have an influence on the identification of mental health needs, or the way that they defend their clients in court, and what implications might this have for their clients' outcomes such as sentencing, or referrals to liaison and diversion schemes? How do they feel about these outcomes? There is currently no research that considers these issues.

The huge numbers of defendants within the CJS who are experiencing mental health difficulties all are undoubtedly of interest to psychology. These individuals may well be better served within the mental health services, rather than the CJS. However, it is acknowledged that if the alternative route is medicalisation, this merely presents a different set of problems. Therefore, the links between these two systems will be explored, but without an agenda of increasing referrals between them.

The literature on burnout has been presented here for readability, however, it was in fact only consulted and written after the analysis stage. Whilst posing many questions for clinical psychology (for example, how do barristers manage such a high workload?), this literature did not inform the research question below.

The research question is framed around the courtroom process, i.e. that of pre-trial, during the trial, and post-trial outcomes. The questions therefore address these sequentially: what knowledge and experience barristers bring pre-trial

including how they construct mental health; how they work with clients during the trial, including specific legal actions taken but also how distress is managed; and how trial outcomes could be influenced by mental health difficulties. Due to a lack of substantial research in this area, this study will take an exploratory approach.

1.9 RESEARCH QUESTION

How do barristers work with psychological distress throughout the Magistrates' Court process?

1. How do barristers construct mental health, and what experience do they have of working with clients who they perceive to have a mental health difficulty?
2. How do barristers defend clients who they perceive to have a mental health difficulty, and how do they work with their clients' associated distress?
3. How might a mental health difficulty influence the outcome of the court case, from the perspective of the defence barrister?

2 METHODOLOGY

This chapter details the methodology employed within the study, and offers justification for these methods. Further comment and possible alternatives are discussed reflexively in the final chapter.

2.1 DESIGN

A qualitative methodology is useful when little is known about the topic at hand, and is suitable for broad research questions (Willig, 2013). This research aimed to gain a greater understanding of how barristers work with their clients' psychological distress throughout the courtroom process, an area that has been little researched, and the research questions were broad and exploratory. A qualitative methodology was therefore employed as a means of generating detailed descriptions and gaining a greater understanding of a relatively unknown topic.

Data was collected via individual semi-structured interviews, employing both scripted and ad hoc follow-up questions. This is a useful means of gaining data where the research aim is exploratory, as participants can influence what is discussed, and unexpected items of interest can arise in discussion (Willig, 2013). The flexibility to ask follow up questions also allows the interviewer to probe responses, garnering detailed understandings of the topic.

2.2 EPISTEMOLOGY

Bateson & Bateson (1987) state that those who claim to have no epistemology have a particularly bad one; this is perhaps particularly true of researchers. Arguably, all those involved in producing knowledge should state their epistemological position, for reasons of transparency. In practice, this tradition is more established in the world of qualitative research, where it is more accepted that analysis is an inherently interpretive act; accordingly, a statement of epistemological position allows the reader to understand how this has influenced the research outcomes (Harper, 2011). Position, design, and analysis should all be epistemologically aligned.

This research has been undertaken from a position of critical realism. It offers an alternative to naive realism: that our senses and knowledge can directly represent the world exactly as it is; but also challenges the post-modern idea

that knowledge can be reduced to the means by which we produce it (Pocock, 2014). It is suitable for the purposes of this research as it allows for the examination of how mental health is constructed, acknowledging that “mental health problems” are in fact a socially constructed phenomena, which do not literally exist and evolve within a particular time, place and culture (Ussher, 2010). One can legitimately examine the phenomena of mental health from a social constructionist perspective, considering how language shapes and limits our experience. Yet, the barristers in this study do exist in the real world, in the real system of the CJS. Their actions have real implications for defendants, including their participation in the trial, and their eventual acquittal or sentencing. Whilst the assumptions underlying the CJS is in and of itself socially constructed, this research nonetheless takes the position that there is a real world out there, existing outside of perceptions, constructions and theories, and therefore takes a realist ontological position (Maxwell, 2012). Critical realism is therefore a suitable epistemological position, as it allows both the examination of the constructs held by barristers in relation to mental health, and the linking of this to the external reality of the courtroom, and speculation on the potential implications for defendants.

2.3 ANALYSIS

Thematic analysis is flexible enough to allow a “contextualist” perspective, between constructionism and essentialism, allowing an examination of the meanings made of experiences within their social context, but with attention also paid to the material reality of those claims, and was chosen for this study (Braun & Clarke, 2006). Other more discursive approaches such as discourse analysis can be very helpful for understanding how experiences are constructed, but do not allow for exploration of systems within the real world. This is because epistemologically, reality is considered to be socially constructed and does not exist outside of discourse (Pocock, 2013). As outlined above, this research takes a critical realist position and therefore social constructionist approaches such as discourse analysis were ruled out.

Other qualitative methods are suitable for a critical realist epistemological position, and qualitative methodology. For example, grounded theory can be undertaken from this position, and aims to be inductive. However, it also

requires a high degree of expertise, which as a novice researcher I did not possess, and aims to generate theories, whereas this research aimed more broadly to increase understanding (Willig, 2013). Interpretative phenomenological analysis would also fit with a critical realist position, but would similarly change the focus, in this case to that of understanding the participants' personal feelings and experiences, rather than attempting to describe how they understood their clients' experiences (Willig, 2013). Thematic analysis was therefore considered the most suitable for the research question, epistemological position, and methods; and chosen as the means of analysis.

2.4 SAMPLING

Given the practical impossibility of studying all instances of a phenomena, qualitative research instead necessitates sampling the population in question. A sample can only be considered adequate if errors are small enough to not nullify the conclusions of the research; yet this must be weighed against the pragmatics of analysing the large datasets produced by transcribed interviews. One approach is to aim for theoretical saturation, concluding collection at the point at which no new insights are being generated by additional data (Oppong, 2013). Given the limited timescale for this piece of research, an attempt was made to predict the point of theoretical saturation in advance, and sample accordingly. Saturation is generally reached between six and 12 participants (Guest, Bunce, & Johnson, 2006), and given the length of the interviews (60 minutes), the lower end of this range was considered sufficient. Therefore, eight participants were recruited. Again, for practicality, convenience sampling was used, and participants were found via my contacts in the legal profession, and word-of-mouth. With the exception of the pilot interview (discussed below), no participant was known personally to me.

2.5 SCOPE

As discussed in the introduction, certain exclusions were made in order to focus the work exclusively on the experience of those with mental health difficulties. All participants worked in courts in London, UK. The MC was chosen, as has been discussed in the introduction, and the Crown Court was therefore excluded.

2.6 PARTICIPANTS

In total eight criminal defence barristers took part (Table 1). Five were male and three were female. The length of time that participants had been working as a barrister ranged from 10 months to six years, and their rough estimates of the number of clients they had seen ranged from 100 to 1000. Their relative inexperience reflects the career structure outlined in the introduction, whereby those practising in the MC tend to be the most junior barristers. Participants were not specifically recruited based on gender, race or age. However, the percentage of males in this sample (62.5%) is very close to the national average of 64.2% male barristers (The General Council of the Bar of England and Wales, 2014).

Table 1: Participant Demographics

Participant Number	Name	Gender	Years Practicing as a Barrister	Estimated Number of Clients Seen
1	Joe	Male	3 years	About 1000
2	Matt	Male	5.5 years	About 500
3	Jess	Female	10 months	About 100
4	Jen	Female	2 years	About 200
5	Tina	Female	5 years	About 1000
6	Lee	Male	6 years	400 to 500
7	Ben	Male	2 years	250 to 300
8	Max	Male	2.5 years	500 to 600

The discrepancy between the number of years practising as a barrister, and estimated number of clients seen, reflects various things. Some participants, e.g. Max, included clients they had seen when working as a paralegal (prior to becoming qualified as a barrister), inflating their total; whereas others may have had repeat clients, or lengthy cases, lowering their total.

Three participants came from the same Chambers in London (participants 5-7: Tina, Lee and Ben). Only limited information can be given about this Chambers, due to the potential risk of identifying them. However, as a very large Chambers, three participants represent less than 5% of their total number of employed barristers. Therefore, whilst the potentially biasing effects of drawing from one Chambers were held in mind during the analysis, it was expected that the large numbers of barristers working there reduced this risk.

2.7 MATERIALS

Materials included a Dictaphone, a printed interview schedule, a password protected computer, and Nvivo 10 software for data analysis.

2.8 CONSTRUCTION OF THE INTERVIEW SCHEDULE

On the basis of the limited literature available to me, I constructed a pilot interview schedule which was trialled on a friend of mine who worked as a barrister. I amended the schedule on the basis of his feedback and data gathered. No service user was consulted during this process. The finalised interview schedule was then used with all eight participants (Appendix A).

The schedule was designed to mirror the courtroom process as described in the research question, i.e. the constructs and knowledge that was brought to the trial, how they defended the case and managed distress during the trial itself, and their thoughts on outcomes. Since a working assumption for this thesis was that barristers would not be trained in mental health and that this might be problematic, this was specifically queried, as well as what kinds of training might be useful.

As exploratory research, with little directly relevant research to guide the questions, the schedule was designed as a series of jumping off points for discussion. Prompting was given to elaborate and points reflected back or queried, as is typical within semi-structured interviews (Willig, 2013). The participants were, not unexpectedly, keen orators with much to say. Therefore whilst the schedule may perhaps seem to consist of more closed questions than is typical in qualitative research, the interviews themselves were open and exploratory. An extract is provided in Appendix B for illustrative purposes. For

these reasons, the extra prompt question was not used in any case, as the participants provided these details in their discussion of the other questions.

2.9 ETHICS

Participants were given an information sheet in advance, and encouraged to ask questions, before signing the consent sheet (Appendix C, D); a copy of the information sheet and consent form was left with them. Participants were advised of their right to withdraw, although none did so. All transcripts were anonymised (i.e. using pseudonyms and changing identifying references). Data was stored on a password protected computer. Audio recordings will be destroyed after completion of the viva, and any required amendments are made and accepted by the examiners and graduate school. Transcripts will be destroyed after three years. Whilst the interview was not expected to be upsetting, contact details of a generic support association was offered to all participants post-interview (The Samaritans).

Ethical approval was sought and obtained from the UEL School of Psychology Research Ethics Sub-Committee (Appendix E).

2.10 PROCEDURE

All interviews took place in a private room at participants' place of work, with the exception of one that was held in an interview room at the University of East London. Consent was taken as described above.

The semi-structured interview was then audio recorded. Interviews were intended to take around 50-60 minutes, which was the case for all but one of the interviews, which took 1hr 30 minutes (Max). Following the interview, participants were offered time to debrief and ask any further questions. The audio-recording was then transferred onto a password-protected computer, and transcribed.

2.11 TRANSCRIPTION

I completed all transcription myself, using an adapted transcription scheme (Appendix F). This was relatively simple and did not capture very detailed aspects of the verbal data (e.g. intonation), as this was not considered necessary or useful to answer the research question (Braun & Clarke, 2006).

However, a verbatim, word-for-word account was recorded, and relevant non-verbal data was also transcribed (e.g. “[laughter]”). Punctuation was used for comprehension, whilst aiming to remain true to the intended meaning of the original speech.

2.12 THEMATIC ANALYSIS: SIX STEPS

Thematic analysis was used to analyse the data, following the steps outlined in Braun & Clarke (2006) (see Appendix G for this information presented in a table).

2.12.1 FAMILIARISING WITH THE DATA AND INITIAL CODES

Familiarisation with the data began by listening to and transcribing all interviews. Notes were kept on reflections, questions, and ideas, which were kept in mind during coding, and the later construction of themes (Appendix H). Transcripts were imported into Nvivo 10, and read through a final time, before starting the process of coding. This software supports “automatic coding,” but this was not employed and all coding was completed manually.

As the aim was for the final themes to be “data driven,” rather than “theory driven,” the entirety of the features of the dataset were coded, rather than only specific content. Whilst all data was attended to, inevitably some codes were guided by the research question. For example, I particularly coded for constructions of mental health, whilst remaining open about what those might be. Line by line coding was used, attempting to capture as much detail as possible about the data (Appendix I). Due to using data analysis software, it was possible to have large numbers of codes. The final list is presented in Appendix J and consists of 511 codes. The process of organising these into themes began quite early as the list became longer, and I organised these hierarchically for ease of use (Appendix K).

2.12.2 SEARCHING FOR THEMES

Searching for themes involved sketching out a preliminary “map” of the data, using pencil and paper, which were initially very rough. I used memos that had been made during transcription and coding to guide my thoughts, as well as the initial process of categorisation that had taken place during coding. Additionally, one feature of Nvivo allows cross-tabulation of codes, which was a useful way

to consider relationships. As I sketched, I organised codes into potential themes using Nvivo. The thematic “map” was re-sketched on several occasions, as themes were revised (Appendix L). Organising the codes whilst still coding is a slight divergence from the referenced process. However, thematic analysis is a flexible model and allows for such creativity (Braun & Clarke, 2006). Eventually, all codes were organised into proposed themes.

2.12.3 REVIEWING AND DEFINING THEMES

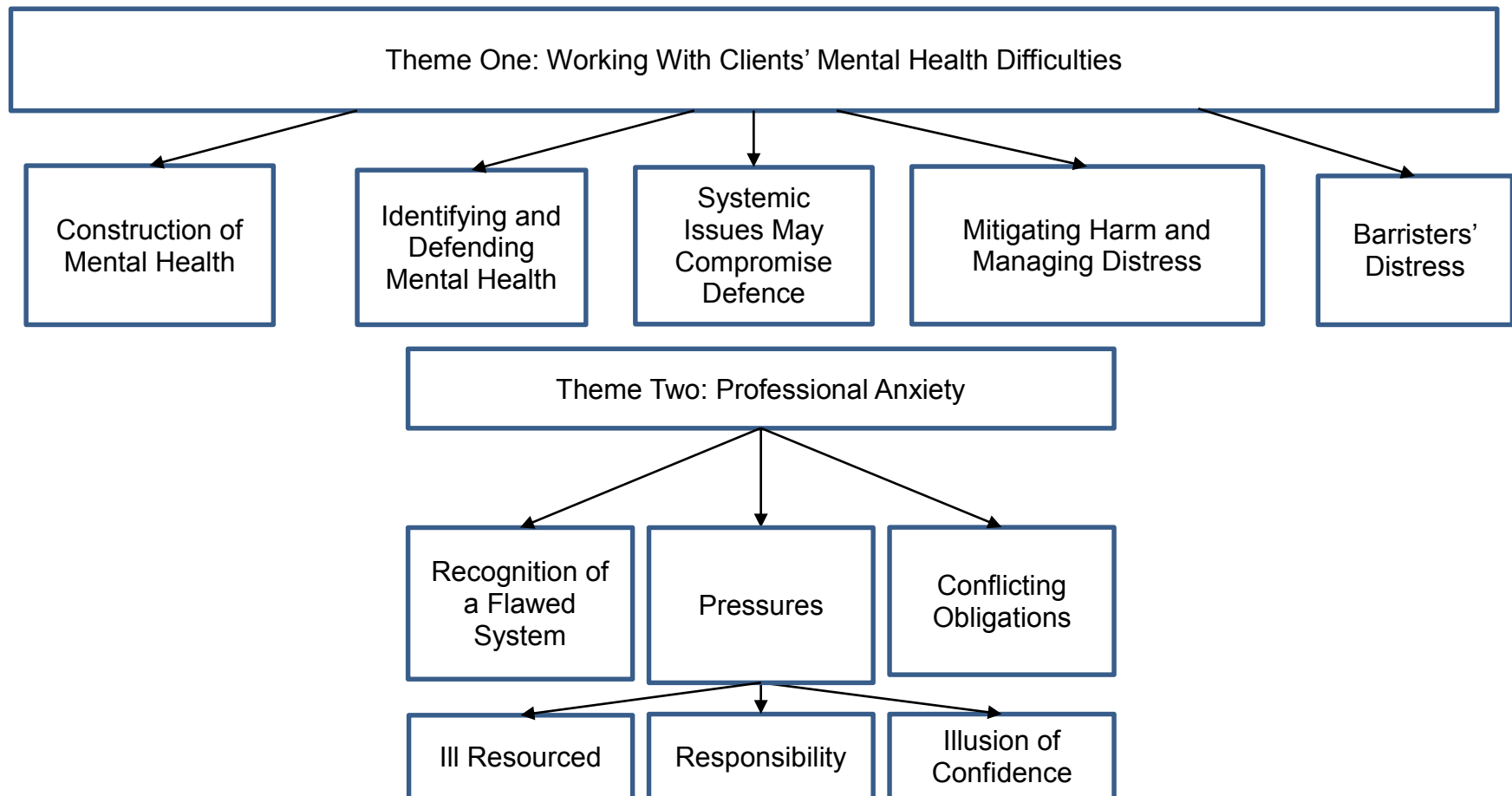
Proposed themes were then assessed for internal homogeneity and external heterogeneity (Patton, 2002): looking for data within a theme to hang together meaningfully, and data between themes to be sufficiently different and distinct. Some subthemes were collapsed, as they contained similar content. All themes and subthemes contained data from more than one participant. Where apparent contradictions emerged in a theme (e.g. one participant had very different opinions), these were noted but kept within the theme, and brought into the analysis.

These candidate themes were then reviewed against the coded data extract, to see if the content matched the thematic description. This was made simpler by Nvivo, as data is collated very easily. Finally themes were reviewed in relation to the entire dataset, by re-reading the transcripts. Arguably, this step is particularly important when using data analysis software, as the coding can become completely decontextualised. The themes identified seemed to tap into the meanings present in the dataset as a whole. Finally, themes were defined, described, and interpreted; and a final thematic map produced; presented in the following chapter.

3 ANALYSIS

Thematic analysis generated two overarching themes for the data, illustrated below in Figure 2:

Figure 2: Thematic Map



N.B. repetitions, and filler words have been removed (e.g. “mmm”). See Appendix F for transcription scheme.

3.1 THEME ONE: WORKING WITH CLIENTS’ MENTAL HEALTH DIFFICULTIES

This theme considers how barristers construct and work with mental health difficulties. The five subthemes describe how their clients’ mental health is constructed, identified and worked with including issues of paternalism and autonomy; the systemic issues that may compromise the defence and how the harm of this is mitigated, and how barristers manage both their clients’ and their own distress.

3.1.1 CONSTRUCTION OF MENTAL HEALTH

Many of the participants remarked on the difficulty in defining mental health and paralleled this with the similarly difficult business of diagnosis, feeling it “was to an extent impressionistic” (Joe, 672–673), and contrasting this to other types of diagnosis, “I guess that’s the nature of mental health, it’s not as easy to diagnose as like a physical ailment,” (Tina, 447–449). Participants varied in what they considered a mental health difficulty. Most named more obviously unusual experiences such as paranoia, or diagnostic labels such as psychosis. Some participants also included depression and anxiety, and these participants tended to give higher estimates of the proportion of clients they’d seen with mental health difficulties, for example,

“There’s a really large number who don’t have any obvious diagnosis [...] so maybe milder forms [...] most of the people that I’ve dealt with in the Magistrate’s Court have got some sort of mental health issue.” (Tina, 35-40)

Whereas Jen, Matt and Jess appeared to only be talking about a particular group of clients who had more obviously disturbing difficulties, attributing less severe distress to the stress of the trial,

“There are some things which you sort of expect as part and parcel of the court process, so you get people who’re exhibiting anxiety, or complaining of symptoms which taken together could amount to depression, and that’s

understandable [...] and then you get people like Mr X, with his schizophrenia slash paranoid delusions slash psychosis.” (Jen, 474-480)

All participants talked about how mental health might be differently constructed within a courtroom setting, and many remarked on the dilemmas posed when medical and legal constructs clashed. For example, most with a mental health diagnosis would still be considered fit to plead; or conversely, Ben discusses one client who was unfit to plead, yet not covered by the mental health act, leaving him in a legal limbo:

“He cannot be tried for criminal defence, because he is what’s considered unfit to plead, and essentially nothing can be done with him because he also doesn’t fulfil the criteria to be detained under the mental health act, or have a guardianship order imposed on him.” (Ben, 66–74)

Most participants commented that access to support within the court room was dependent upon reification of an illness, either in the form of observable behaviours in court, or a medical diagnosis. Many participants commented that mild issues were unlikely to be taken into account. This resulted in a Catch-22 situation for barristers who wished to get an adjournment in order for their client to have a psychiatric assessment, as Magistrates were reluctant to grant this without the evidence of a diagnosis:

“When it’s put with somebody who doesn’t have an obvious problem, it’s even harder, because you’re saying, okay, take it on faith, that I think there’s a problem but I don’t really know what [...] and they’re really reluctant to do that [...] I think there’s definitely a difference when somebody has been diagnosed.” (Tina, 112–123)

On the whole, participants felt quite unclear about what personality disorder was (“I don’t know what it actually means,” Jen, 481–482), a diagnosis that is a fundamental to the old psychiatric, “mad or bad” debate.

Within the accounts given by participants, there appeared to be something of a division in the way they understood their clients’ difficulties. Some participants took into account contextual factors such as poverty, social difficulties or related problems with alcohol or drugs when explaining mental health problems. Other participants

seemed to draw more from a medical narrative, using the language of symptoms, disorders and illnesses to think about their clients. These were not absolute ways of understanding their clients, and most participants occasionally expressed a combination of these perspectives. For example, viewing clients as, “sick,” (Tina, 149), or “pathological,” (Joe, 293), whilst simultaneously holding a contextualised perspective on their clients’ experiences: “but to me I think there’s a spectrum,” (Tina, 18). However, on the whole the participants tended to discuss difficulties framed by one or other of these perspectives. Ben, Lee, Jen, Tina, and Joe took a largely contextualised view of their client’s distress; whereas Jess, Matt, and Max, expressed more medicalised perspectives.

A contextualising position seemed to relate to understanding mental health as a spectrum of difficulties, rather than the categorical model of diagnoses. Jen framed her thinking outside of a medical model, and instead talked about a wider conceptualisation of “the vulnerable client” (160) to also refer to difficulties such as learning disabilities. All participants speaking from a contextualising position talked about psychosocial factors that may have caused their clients’ distress, for example Ben:

“Depression itself is something that is a damaged person essentially.” (Ben, 360)

Participants had an awareness of their clients’ related social issues, and made meaning out of “symptoms,” as illustrated by Lee:

“I would construe [mental health conditions] quite widely, so I would include depression, I would include stress. [...] I think I’m justified in construing it [...] that widely, because I think depression can lead to abuse of drink or drugs, or for relationships to fall apart, and I know stress can lead, to take not that an extreme example actually, people that have never been in trouble before reacting slightly violently to stressful situations.” (Lee, 467–478)

They also took into account the context of the trial itself. Most participants described how the stress of the trial might interact with their client’s prior distress or

vulnerability, with some clients' pre-existing difficulties made much worse, for example,

"[Clients with diagnosis of PTSD may] not [be] able to recount that properly [in court] and that leads to a great extent to the re-victimisation of those people." (Ben, 434-347)

Matt, Max, and Jess spoke from more of a medicalised position, using more language like "illness" (Max, 140) and "symptoms," (Matt, 45), and elaborating less about related psychosocial issues. They appeared to think more along diagnostic and categorical lines than a spectrum of difficulties, for example,

"Lots of them have addictions but I don't think that counts, it's not something that I would classify as a mental health problem [...] I don't know whether that falls in your categorization." (Jess, 345-350)

They used more reifying language, such as, "if the defendant really is suffering from a mental disorder," (Jess, 205) and tended to talk more about deferring to "mental health experts," (Max, 148).

3.1.2 IDENTIFYING AND DEFENDING MENTAL HEALTH

In a later theme, "systemic issues may compromise defence," participants describe that failing to identify or disclose mental health needs could lead to poorer outcomes for clients. Despite this, however, most participants were thoughtful about weighing this up against the potential costs of identifying mental health needs, using mental health as a defence, and the consequences of psychiatric assessment.

3.1.2.1 DISCLOSING MENTAL HEALTH NEEDS TO THE COURT

Participants varied in the extent to which they considered the court room staff prejudicial towards mental health difficulties, perhaps reflecting their different professional experiences of MC work. Matt, Tina and Max felt that if clients had the legitimacy of a clinical diagnosis, the courts were "sympathetic" (Max, 341), and would strategically seek diagnosis if they felt this would be in their client's best interests. With the exception of Jess, who did not discuss mental health at all, other participants tried to keep disclosures of mental health from the court at the defence

stage, as they had little faith that disclosing psychological distress, or diagnosis, to the court would be helpful to their clients' outcomes:

"The really sad cases really, are the ones where for example someone has had a really tough personal life, has developed depression or anxiety because of that [...] I have heard magistrates say, when you bring up the issue of depression, oh well everyone who comes before us has depression, or whatever issue, it's not something that we take into account, they all have it." (Ben, 703–730)

3.1.2.2 IDENTIFICATION OF MENTAL HEALTH

When describing how they might raise mental health with their client, most participants demonstrated sophisticated interpersonal skills, employing a range of tactics depending on the individual client.

Tina described attempting to build "some kind of trust, so that you're not some stranger," (25). Ben expressed sensitivity to the fact that the question was "not the context that they expect to find in" (87), and an awareness that, "even people that suffer from mental health issues do internalise the stigma," (77). Some participants felt it was best to "ask in a matter-of-fact way, I don't make a big deal out of it," (Lee, 45) so as to not seem judgemental; whilst others felt this could be "dangerous," (Jen, 560), and used indirect methods such as attempting to assess their thinking, or use of a hypothetical other to introduce the topic:

"You know you seem to me to [...] to be absolutely fine, however, you might understand that maybe somebody who looked at this, like the police officers have, like so and so has, might be concerned that you're not well, or weren't well at that time [...] I always put it as a kind of exploratory question [...] I mean that seems to be okay, it didn't seem to upset anyone." (Joe, 325–350)

Joe and Jen mentioned a real risk of violence associated with these conversations:

"He had a history of being like this and then getting very violent (.) So (1) I couldn't, I couldn't raise it with him." (Joe, 345–347)

Some participants recognised a risk to their relationship with their client, although Lee found that raising mental health could potentially help, “in many respects it’s a way where I can gain their trust I think,” (Lee, 52–53).

3.1.2.3 ADOPTION OF A MEDICALISING OR CONTEXTUALISING POSITION

As discussed previously, participants tended to be more committed to either a medicalised or contextualised understanding of mental health. These understandings seemed to position the participants in different ways, potentially constraining their possibilities for action, or opening up particular options. Some speculation on how barristers’ interactions with clients or the court might flow from these positions is now presented.

Participants speaking from a contextualising position were more likely to report that clients wanted to discuss their mental health. They felt that it was quite likely that their client’s mental health needs may not have previously been identified. Tina felt that as most of her clients were from disadvantaged backgrounds, “they don’t necessarily get referred into the health system and that’s why they’ve never been diagnosed with anything,” (Tina 63), and Joe explained that therefore, barristers may end up having to look out for these needs, and decide whether or not to refer:

“[Barristers] are the ones who, except in (.) very, quite unusual circumstances, they are the ones upon whom it falls to make the initial decision about whether to refer.” (Joe, 114–118)

Participants who adopted a medicalising position were more likely to name a reluctance to discuss, or masking, of mental health difficulties. This may have related to the way the question was framed:

“You’d sort of think well I can just ask you straight up, you’re a schizophrenic or, you know, or you’ve got Asperger’s, or bipolar and sometimes when you ask them straight up [laughter] they say, “I’m fine, I don’t know what you’re talking about,” and then, sort of look you with a [laughter] slightly sort of unpleasant look, as in, how dare you.” (Max, 971–981)

Jess appeared to adopt a very medical understanding of mental health, and therefore felt strongly that it was not a barrister's role to identify this. She explained that:

"It would be a rare case that someone came to a barrister first of all, without ever having been caught in the system somewhere else [...] I certainly haven't come across it." (Jess, 421–428)

Jess' understanding of mental health appeared to position her as feeling it was nothing to do with her, as she was not a mental health expert. This appeared to constrain her opportunities to discuss mental health, and she described never having asked clients about their mental health; neither had they spontaneously disclosed it. Similarly, whilst feeling it was a, "horrendous system," (265), Max appeared to feel totally disempowered:

"You're not the doctors, you're not an expert in mental health, and these rules have been brought about by judges, by consultation with the medical profession. So I think you have to unfortunately, take a step back and say, look well that's the process that's been designed." (Max, 255-265)

3.1.2.4 PATERNALISM VS. AUTONOMY

Participants adopted different strategies when faced with clients who were apparently less able to make rational decisions. Joe felt that for many of his clients, a trial was a chance to restore dignity, and that for some clients, the trial process was more important than the trial outcome. Joe therefore primarily considered his role to be supporting their autonomy:

"In a way it vindicated that you act on your instructions, regardless, and for some people actually, the criminal process is more important than the result and people want to have a trial and they want to see that it's done fairly (.). Sometimes that's undermined by bad prosecution but it can be undermined by bad defence as well, people compelling somebody not to have a trial." (Joe, 265–272)

Jen felt empowered to fight the system by assuming responsibility for her clients, perhaps due to seeking advice from a senior colleague. Whilst many participants

described the generic mental health defence⁹ available in MCs as discriminatory and disadvantageous, “it deprives him actually of a whole defence,” (Max, 222), they still did not take Jen’s more extreme position of instead running the trial on their behalf. She explained that this necessitated a higher burden of proof: “if (the prosecution) have to prove intent, then they’ve got to prove state of mind, so if your client gives evidence that he’s actually a tomato [then they can’t]” (Jen, 135–137), and thereby gave them greater chance of acquittal than using fitness to plead proceedings, which she described as, “you’ve basically folded.” (250)

Tina assumed responsibility for her clients. Arguably, this led to legal paternalism, feeling that some clients were not “capable of telling you what is in their best interests,” (252–253) and she would therefore attempt to decide these for them, for example, persuading clients not to go to trial:

“But she was adamant she wanted to run this, she wanted to plead not guilty and have a trial and I tried to explain to her lots of times, it’s not in her best interests.” (Tina, 316–319)

Unlike most other participants, Tina viewed getting her client into hospital as a potentially helpful treatment:

“I tried to explain to him again and again, you’re not well, but he didn’t want to go prison and whatever, so we had to adjourn it quite a few times, just firstly to get him into hospital.” (Tina, 379-382)

All other participants attempted to resist paternalism where possible. Some participants considered the impact on engagement when wondering whether to refer someone to mental health services:

“Because you don’t want to just immediately go referring them to some mental health services if it’s not of assistance to them or if it’s just going to make them

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A trial of the facts, which could potentially lead to a hospital order (see table on page 16 for further details of specific legal processes)

disengage and it's going to harm their ability to engage with the criminal justice system.” (Ben, 599–603)

Several other participants weighed seeking diagnosis up against potentially negative consequences, considering that mental health services could be restrictive:

“[Mental health services] don’t always work to your advantage if you’re coming at them through criminal justice, because you end up with restrictions in Broadmoor and you never get out.” (Joe, 1076–1079)

Jess’ reluctance to discuss mental health linked to a deep respect for the client’s autonomy, for example explaining that requesting a mental health assessment might, “put them in a position perhaps where the defendant doesn’t want to be examined and doesn’t need to be examined.” (154–155)

Rather than directly raising mental health with the court, many participants instead attempted to get the prosecution to drop the case. This sidesteps the need to either medicalise or criminalise; unfortunately as will be discussed, this approach was often met with limited success.

3.1.2.5 THE LIMITS OF AUTONOMY

Joe, Matt, and Max all also spoke of the social control function of the CJS. Whilst their primary duty was to defend their client, they appreciated that autonomy needed to be weighed up against a duty to protect the public from harm:

“You have to bear in mind as well, if someone is dangerous or is doing antisocial things, then, you know, that is, there is a social concern there, I fully accept that when I defend, that’s fine. So the question is balancing that appropriately.” (Matt, 582-586)

Max regretfully described a case in which he felt the provisions meant to protect those with mental health issues had been taken too far, with someone potentially guilty of very serious crimes acquitted.

Jen, Matt, and Joe all spoke of tempering their support for autonomy with an overall sense of duty of care:

“I mean if you had, if you had a severely unwell client who obviously needed to be in hospital that’s one thing.” (Jen, 297–298)

“I spoke to the guy on the phone, and he said [...] somebody raised mental health, awful [...] we’re going to plead, you should always go to trial, and I was like, what are you talking about? This guy is guilty, [and] he needs to see a doctor before he kills himself.” (Joe, 1105–1109)

These illustrate the barristers’ feelings that in exceptional circumstances, health should be privileged over freedom.

3.1.3 SYSTEMIC ISSUES MAY COMPROMISE DEFENCE

Participants talked about a number of systemic issues that might compromise the defence of their clients with mental health needs. These included a vulnerability to courtroom pressures, the stress and competence of their defence barrister, perceived bias towards the prosecution, and courtroom ignorance and discrimination.

3.1.3.1 VULNERABLE TO TIME AND FINANCIAL PRESSURES

With the exception of Jess, all participants discussed the immense time and target pressure in the MC; with many barristers feeling the purpose was to simply process cases, rather than deliver justice:

“There’s a massive drive to process [...] we have to make progress, we have to keep it going, we have to resolve, when it’s not always the best course.” (Tina, 57–61)

Many participants discussed why this was particularly problematic for their clients with mental health needs. Several described that taking instructions “is more difficult,” (Lee, 105–109) and identified various difficulties in communication, and engagement, that meant they required extra time.

Communication difficulties included: “people either don’t seem to understand or they’ll go off on a tangent,” (Tina, 52); and the dangers of acquiescing: “What they do is they just agree to everything that you’re saying, when they don’t actually understand what you’re saying,” (Matt, 74–75). There were difficulties reported in

clients getting to the solicitors appointments prior to the case, or to the court itself: “The day of her trial, she refused to leave her house, because she thought her ex-husband was going to murder her on the way to court,” (Jen, 156–160). The client’s distress could lead to difficulties obtaining instructions: “She was so upset, she couldn’t engage, and it took about half the day to be able to get yes or no answers to really straightforward questions (Jen, 161-163). Similarly, bizarre or apparently illogical requests from the client could conflict with the barrister’s responsibilities to the court leading to impasses. For some clients, processing large amounts of information could prove problematic: “If you’ve been given a ton of material, expecting someone who can’t focus to go through an inch and a half’s worth of paper is just not fair, and it skews the whole process” (Jen, 437 – 440). Courts were also described as unwilling to give time to request an adjournment for assessment of mental health needs.

Several participants described that effectively defending clients with mental health needs took a huge amount of work, which due to recent cuts in legal aid, they would not be paid for:

“I did eleven appearances for the princely sum of £80 [...] I think I worked it out at about 40 hours of work.” (Jen, 699–703)

“You know, some days you can earn less than what someone working on 9-to-5 shift at McDonald’s minimum wage might earn.” (Max, 1368–1371)

Whilst Jen felt that barristers would be unlikely to see this as a disincentive to adjourn, Matt was concerned that:

“The vast majority of the time, frankly, I, you know, I don’t know how prepared people will be to devote that kind of time to a very sort of work-intensive but low paying case,” (Matt, 319-323),

with Max taking this further, and expressing ethical concerns about the impact of financial pressures on barristers:

“[Barristers] are becoming obsessed with getting the money so they are making decisions based on financial consequences as opposed to making decisions in the best interest of the client. Now of course, if you asked anyone directly, do they

do that, they'll say, no because they'll be in breach of professional ethics, and it's a disciplinary. But you see it." (Max, 1397-1401)

Lee described that the drive to process defendants led to "unfair pressure to plead guilty," (327) as did Tina. She additionally explained that due to cuts in legal aid, some clients did not qualify for any representation at all, potentially leading to miscarriages of justice.

Several participants spoke of their concern that the intersection of these time and financial pressures, with the multiple disadvantages faced by their clients with mental health needs, made miscarriages of justice likely; and that a failure to identify mental health could have serious implications for their clients:

"[It has implications for both their defence and] the way everyone deals with them [...] on top of which, not just defence, but sentence, sometimes the medical situation has far more implications for sentence." (Max, 1050-1052)

Max also expressed concerns that financially-driven unethical behaviours by barristers could lead to:

"Miscarriages of justice, leading to the wrong decisions being made, leading to people's best interests not being protected and okay, I think that's a real concern to for the average person and a massive concern for someone that needs care." (Max, 1420–1425)

3.1.3.2 STRESS AND COMPETENCE

The incredible stress on junior barristers, and lack of training and support, could potentially lead to poorer outcomes for their clients. Matt explained the problem with having to learn on the job:

"Interviewer: So your very first clients, with these difficulties -

Matt: -they're like basically a, almost like a test case for you. They don't know that! <no> but that's what they are." (Matt, 652-655)

Max described how stress could lead to:

“You’re just going to neglect their needs [...] if you’re tired and stressed, and already, you know, exhausted mentally from the pressures and stresses and the upsetting nature of the job, you’re not going to be able to look after them properly.” (Max, 733-744)

3.1.3.3 BIAS TOWARDS A PROSECUTION

Many participants perceived that, “there’s a bias towards a prosecution,” (Lee, 48–49) in the MC. Additionally, whilst vulnerable witnesses are afforded particular safeguards in court such as an intermediary, vulnerable defendants are not:

“There is a skew in the system which is, you know, he’s the accused, he shouldn’t get as much support because he’s probably done something wrong.” (Max, 314–317)

3.1.3.4 COURTROOM IGNORANCE AND DISCRIMINATION

With the exception of Jess, all participants described widespread ignorance and discrimination towards mental health in the MC. Many expressed a need for comprehensive training for court staff. Several participants described “a culture of disbelief,” (Ben, 280). Most participants felt that magistrates were prejudiced against those with mental health needs, and therefore describe advising the client not to disclose this to the court:

“I’d love it to be the case that [Magistrates] would look at it sympathetically, consider it in the right light [...] I think most people are prejudicial and they say, somebody’s been in the street, shouting, swearing at officers. They’ve got a mental health condition! There we are! We know what happened. So you don’t mention it.” (Joe, 975–985)

Joe felt uncomfortable that this could potentially perpetuate shame,

“It’s a shame, because you know (2) in a sense maybe those people then think, that shame about mental health conditions is something that’s encouraged in the courts, we shouldn’t talk about this, you know, and I feel, I feel very strongly that, that’s a bad thing.” (Joe, 98-991)

Although Max disagreed, and felt:

“Once you get into that territory of a serious recognised mental health illness (Magistrates) do tend to be a bit more sympathetic.” (Max, 952–954).

Whilst perhaps reflecting different experiences of different magistrates, this difference may be speculatively accounted for by their different constructions of distress, as those holding a more contextualised view of their client’s distressed seemed more sensitive to courtroom stigma than those holding a more medicalised view.

Many participants described the particular issue in the MC of Magistrates holding fused powers, where they are dually responsible for hearing matters related to the court process itself, such as requesting extra time, and determining the verdict:

“[In cases where it’s] very often one person’s word against the other and I [need time] to get further instructions from someone who is upset, I don’t want to tell the Magistrates it’s because [of their mental health condition] because the main witness against them may have exactly the same difficulties [but would not have to disclose this to the court].” (Lee, 219-229)

Barristers did not seem convinced that Magistrates would be able to “put a defendant and his previous convictions, or hearsay, out of their minds,” (Lee, 120-122) as: “it requires a mental gymnastics sometimes to think, I know that, and I’m not going to bear that in mind, eh I just don’t think it can be done.” (Lee, 122–124)

Whilst a legally valid defence, several participants said that the prosecution were extremely reluctant to drop cases on public interest grounds. Ben, who had worked in prosecution, felt this connected to other issues of courtroom ignorance and discrimination, and suggested that prosecutors probably lacked training, “I don’t know what training CPS prosecutors have, but it’s, I would assume a particular problem for them,” and that there was a culture of disbelief in terms of mental health. He also felt that, “even if someone was believed [there was] a culture that that it didn’t really matter anyway, you just proceed with the prosecution, when someone’s done wrong they need to be punished.” (Ben, 281–284)

3.1.4 MITIGATING HARM AND MANAGING DISTRESS

Lee described that he felt that all barristers were really doing was, “mitigating the worst aspects of what can be a very, very unfair system,” (900). Many participants talked about the ways that attempted to do this. For example, as an intermediary is not available for vulnerable defendants, Jen described working very hard to ensure the client understood the process; but Lee explained that this was still not as good as an intermediary itself:

“I can’t, between witnesses I can’t rush back to them to check that they’re okay, ask them if they understand something.” (Lee, 197–198)

Most participants were highly aware of their clients’ multiple social disadvantages, and many spoke of the additional strain of assuming the role of a social worker:

“You come away feeling like a social worker, as well as being a barrister you’re also trying to help somebody who’s frightened, or angry, or very very stressed deal with the experience as well as taking their instructions and representing them.” (Lee, 71-75)

Most participants felt their primary task as a barrister was to support their client and engage them fully with a stressful process:

“I might not be the best lawyer [...] but I really do try to make the clients feel comfortable in a very stressful environment.” (Max, 759–761)

However, for their clients with mental health needs, this meant dealing with high levels of distress:

“Just the agony, that hatred of the client and the client’s mother towards me, because they couldn’t understand why he was being remanded [...] Both of them became irate, hysterical, the mother had to be taken from the courts because she spent every minute that she was there screaming at me.” (Max, 472–482)

Most participants expressed a wish for training in how to work with and engage these clients:

"I have had no training whatsoever in how to deal with the fact that he has paranoid psychosis. All that I can try and do is [...] use the general interpersonal skills that I have to try and placate him and calm him down and guide him through what is often for him, quite a distressing court process." (Ben, 72–80)

Several participants had experienced aggression, and Jess expressed a wish for training on managing this. Many participants said that some distress was normal, but that very abnormal behaviour was not manageable, and were often feeling very unsure about what to do:

"[Her client said]: 'You've got to be able to see this, this is a receipt from an erotic website, my husband's been selling pictures of my daughter,' and you're going, that's a blank bit of paper, I don't know what to do, oh [sighs]." (Jen, 152–155)

Or how to manage this in court, which due to issues raised earlier, were often left to barristers to deal with:

"She would not stop shouting while her husband was giving evidence, and there's absolutely nothing you can do about it and the Magistrates don't know how to deal with her." (Jen, 145–148)

Many participants named "suspiciousness" (Jess, 317) as very difficult to work with, as it prevented clients from engaging with them; and sometimes led to difficult impasses:

"They keep accusing you of, of not working for them, or working for the court and not being independent [...] When they doubt that, and continue to doubt it, it's almost nigh on impossible." (Lee, 490–498)

Whilst they had received some specific training on risk, it was clear that this did not include how to conduct a risk assessment, which is concerning, given the high levels of distress that barristers had to deal with:

"I didn't know what to do with him, because at times he would say things like, you know if they keep me in here, I don't see what the point is of trying to obey the rules and trying to do things well, I'm just going to go off the edge, I'm going to do

whatever, you know words to that effect. He eventually calmed down so I didn't do anything." (Jess, 170-176)

As previously mentioned Jess felt her role did not include discussing mental health with her clients, and that looking out for the defendant's overall welfare would "side-track" her (112). Given the immense stress and distress expressed by the other participants, this seems like an adaptive response to her situation, as she describes below:

"There are so many problems that each one of them has and you initially feel, you know, the first couple of clients you get you feel, well you know all these things should be able to be sorted out and once you see enough of them you realise that, if you, to survive in the job, as a matter of our own mental health I suppose, you have to confine yourself to the matters that you can actually deal with." (Jess, 268-274)

Lee came to a similar conclusion, feeling incredibly burdened by assuming responsibility for his clients' social issues, and eventually realising:

"Oh, that's not actually my role, my role is to simply [...] to ask questions and give a speech on his behalf it's not, to try and calm them, take their instructions, help them not to panic or freak out in the witness box. I felt there was far too much being asked of me." (Lee, 425-430)

3.1.5 BARRISTERS' DISTRESS

Given the degree of uncertainty, stress, and emotional intensity associated with the work, and barrister's feelings of personal responsibility and poor access to support, it is unsurprising that many of the participants expressed a high level of distress.

Most participants described the high emotional price of having to work with very distressed clients:

"I spent four days in a, in a trial with somebody who just wept, all day, every day and I've never seen anything like it, and it was very very distressing for everybody." (Joe, 183-186)

Some participants described that it was a part of the job that you were meant to get used to, but this was difficult:

“Part of the job, you’re meant to get used to it like a doctor, who loses a patient, but [...] it can end up being massively traumatic.” (Max, 468-476)

“You don’t really forget them, each case is individual and each person is individual [...] But you have to be able to just drop it from your mind in order to get on with the next person the next day.” (Ben, 365–368)

Ben described the horror, and impact, of reviewing violent evidence:

“You come to the photos of the crime scene, and someone’s mutilated burnt decomposed body, it is, it does have an effect on you and if you weren’t just dealing with looking at the photos of that but maybe watching a video of the murder itself, for instance that, that would have a massive effect.” (Ben, 350–356)

Many participants described feeling helpless, sad, or angry. Feelings of exhaustion were common, which made it harder to manage clients with mental health difficulties:

“I must have done two or three months of a trial every day [...] and by the end of it, you know I was exhausted, physically and mentally and then on top of that if you suddenly have very difficult mental health clients, your capacity to cope is seriously weakened.” (Max, 711-717)

Ben described that without training and resources, “I think inevitably it’s going to lead in many cases to, to damage, and that damage may well be that you just stop caring” (Ben, 413-415).

Several participants described as it being “very very distressing,” (Max, 544) when their clients were convicted, appreciating their vulnerability within the CJS:

“They can barely comprehend what’s happening to them [...] if you’re vulnerable there are people in (prison) who won’t be nice and won’t go, oh don’t mess with him, he’s disabled, or he’s got a mental health problem. They’ll take advantage of you. “(Max, 549 – 563)

Distress was most pronounced for the junior barristers, linking to the issues raised in the next theme. Lee described feeling preoccupied and “struggling to let things go,” (176) in his first couple of years as a barrister, feeling personally responsible and completely overwhelmed:

“I used to go home thinking that I, I was somehow to blame for my client being convicted, despite the fact that the evidence was overwhelming.” (Lee, 208–210)

“I think some [barristers] really, not quite crack, but get quite close to that times, they feel that cases are upsetting, they feel inadequate, [...] It felt sometimes like this guy needs, like I can’t cope with everything he needs of me right now.” (136-141)

Many participants expressed distress at having to work within a system with which they disagreed. Their understanding of this is explored more fully in the next subsection, “recognition of a flawed system.”

3.2 THEME TWO: PROFESSIONAL ANXIETY

The name of this theme is taken from an extract by Jen, describing the overwhelming sense of responsibility she felt for her clients, while simultaneously recognising that she may not be capable of meeting their needs. The five sub-themes consider the barristers’ recognition that they work within a flawed system; the specific pressures they face of poor resources, feeling personally responsible, and the need to appear confident; and the ethical dilemmas faced when working in such a context.

3.2.1 RECOGNITION OF A FLAWED SYSTEM

Several participants felt that the purpose of the CJS was fundamentally at odds with their own values, being in favour a system based on rehabilitation, rather than punishment:

“It’s not really designed for a modern understanding of why people commit criminal offences, it’s still coming from the angle of people commit offences because they are bad people, it’s not aiming to really fix people for the future, so it is unreasonably focused on punishment over reform.” (Ben, 317-322)

Many participants described a wish for the CJS to help people, on either an individual or societal level. Dealing with people with mental health problems in the CJS was perceived to serve neither purpose:

“The CJS [...] shouldn’t be about how we get some 50-year-old alcoholic off the streets for a few weeks (.) It’s just not designed for that, there are really no social benefits that come from putting people like that through the CJS.” (Ben, 328-332)

Furthermore, on an individual basis, the CJS was described as particularly detrimental to those with mental health problems. The stress of a trial was perceived to be particularly aversive, due to these clients’ reduced ability to manage stress. With the exception of Jess, all participants felt that the CJS was not the appropriate place to deal with these clients, and expressed a wish for diversion to community care:

“Criminal prosecution I don’t think is the answer in a huge amount of these cases [...] Where they’re first-time offenders, where the damage done is minimal, when no harm, no real harm has been caused, I would like to see a divergent where they don’t get like a record.” (Lee, 25–42)

While such diversion schemes exist, several participants identified recent cuts to these services. Courts reportedly only had a staffed mental health team one day a week, resulting in the stress and expense of adjournments for some clients, and deprivation of liberty to others remanded in custody whilst they waited for the appointed day.

Joe and Tina both described the CJS as a kind of proxy for an ill-resourced community care system, “where [defendants] have to gather a conviction and be dealt with as a criminal before services engage.” (Joe, 542–544). This led to uncomfortable questions about barristers’ duty of care for such clients, and whether by defending their case forcefully, they risked the client’s overall welfare:

“Sometimes even you’re thinking, should I get the prosecution to drop it? Because, if they do, then that’s the end of it, whereas if they carry on, maybe we can get probation intervention. So, there just doesn’t seem to be enough service really.” (Tina, 32-36)

Participants also recognised the process of criminalisation, whereby mental health related behaviours are not treated within health systems, but are instead punished in criminal courts. All participants felt that mental health problems had directly led to a

prosecution for at least some of their clients, and served as a contributing factor to many others; for example:

“Interviewer: So to what extent do you think mental health difficulties have led to your clients being arrested?”

Ben: well (.) To a very great extent frankly, it comes back to that issue of the criminal justice system not being designed as a mental health system, but being used as it.” (Ben, 74 – 78))

However, whilst the barristers may have viewed their clients as less culpable, this did not make them less criminally responsible. It was acknowledged that mental health needs do not generally provide a defence, e.g.: “it’s not a defence to beating someone up that you have Asperger’s.” (Jess, 539–546)

As a group, the barristers were critical of the very function of the CJS, recognising that they wished to help both their clients and society at large, and the tensions of working for a system that comprehensively failed to do so. Only Jess did not comment on this dilemma, perhaps for the previously discussed reasons that she did not think about her client’s mental health.

3.2.2 ILL RESOURCED

Alongside working within a flawed system, poor pressures added to barristers’ professional anxiety. These included a lack of training and guidance, feeling stressed, and not supported. These are discussed in turn.

3.2.2.1 LACK OF TRAINING AND GUIDANCE

None of the barristers in this study had received any training whatsoever in mental health. Most of them identified this as a concern, suggesting a range of topics that they would like training in, given the opportunity. Those who held a more medicalised perspective on mental health thought training in diagnostic categories might be helpful, for example:

“I would have thought some form of training on how to handle people, how to recognise certain illnesses, and if you can recognise the illnesses, how to cope with those individuals and their illnesses” (Max, 45–49).

Those with a more contextualised perspective still thought it would be helpful to be given guidance on how to identify those who might have additional needs, for example, Jen's conceptualisation of the vulnerable client:

"The vulnerable client maybe should be covered as a topic, once practitioners decide they are going down a particular route, simply in terms of, here is most of humanity you'll be dealing with, here is a group or a particular set of traits that you should look out for and when you see these traits, you may need to consider reacting more like this" (Jen, 407–414)

Most participants recognised that without training, their clients' needs might not be fully met, and were concerned about the lack of professional guidance, feeling unclear about their obligations. Furthermore, barristers themselves were left ill resourced: "I think really, it's just a huge gap in education, training and support in dealing with, yeah some just horrifically tragic sets of circumstances" (Max, 25-27).

One participant, Jess, was more hesitant about offering training, feeling concerned about the potential dangers of barristers ending up diagnosing clients:

"Reactions in those kinds of conditions, could be misinterpreted, possibly by, you know, over-eager barristers who are, not, not particularly well aware of what they're looking for and, are suddenly put into some training and being primed to look for an aggressive defendant, or someone who appears very upset." (Jess, 143-148)

She felt that barristers should only concern themselves with legal matters, which as discussed earlier, may have helped to preserve her own mental wellbeing.

Max explained that in addition to the lack of training, there were environmental barriers to barristers identifying mental health needs, with little confidential space:

"[There] may be one room for the whole building, to go and sit and have a private conversation. So often, the instructions are taken on the seats outside of the courtroom," (Max, 1009–1011)

3.2.2.2 STRESS AND PRESSURE

All participants described the enormous stress and pressure of the work, which was often compounded when dealing with clients with mental health needs:

“(Junior barristers) spend most of their time doing cases that are underprepared, that they received at the last minute [...] they arrive early at court, [...] But of course sometimes your client, who is struggling with stress and anxiety, doesn’t arrive until half nine, quarter to, you try to get them to immediately focus on the thing at hand, they want to talk to you about a number of different issues and the stress ramps up. So you go into the courtroom, because the case is called on, you say that you need further time and you get into, the court immediately demands to know why this hasn’t been done, and there’s no answer to that other than, we’re poorly funded, overworked, and we just got the papers at very late notice.” (Lee, 61–79)

The above extract illustrates a number of pressures on barristers, including the increasing financial pressures caused by cuts to legal aid, the lack of time to prepare, and huge workload; none of which is received sympathetically by the court, which is under its own pressure. Additionally, barristers are expected to, “basically sort of learn on the job. It’s learning through experience,” (Matt, 10-11), which means their first cases in the MC are particularly stressful. Some participants explained that these difficulties were recognised by neither the court nor the profession, “I just think there’s no appreciation of how difficult it is whatsoever.” (Lee, 168–169)

3.2.2.3 LACK OF SUPPORT

Many barristers spoke with regret about the lack of emotional support in the profession. Lee described that whilst legal advice was offered, “I didn’t feel that those offers extended to, call me if you need to chat, and just vent,” (191–192). Matt, Lee, Ben, and Max all identified this as, “a problem” (646, Matt), and felt:

“The impact of dealing with clients with mental health difficulties on young barristers and young advocates I think that something that’s not, not enough attention is paid to.” (Lee, 28-31)

Max explained that if you were prepared to self-identify as struggling, some kind of professional support was available; but that due to stigma, taking this up would very likely compromise one’s career:

“In terms of professional standing, if you’re someone that has had a nervous breakdown, been an alcoholic, any of those kinds of things, all of a sudden it will be, well that person can’t cope, it’s not good enough.” (Max, 479–483)

3.2.3 RESPONSIBILITY

Many participants recognised the myriad social issues that their clients faced, and that “the kind of people that we’re dealing with are from disadvantaged backgrounds,” (Tina, 20–21). This compounded the sense of responsibility they held for their clients, which when trial outcomes were not favourable, could be very distressing:

“I used to go home thinking that I, I was somehow to blame for my client being convicted, despite the fact that the evidence was overwhelming.” (Lee, 424–444)

Several participants described a duty of care beyond the trial itself, feeling responsible for the client’s overall welfare despite often lacking the means to address this. This sense of responsibility was intensified when clients were not able to give instructions, as described by Jen:

“The most impressive and also the most terrifying part of my job is that someone effectively goes, “here is my life, please don’t squish it, and don’t drop it,” and when you’ve got someone who’s handing their life over to you, and isn’t giving you any direction you go, oh [laughter], right. Where do we start?” (Jen, 391–396)

Several participants linked these feelings of responsibility to their values and motivations, “I think there’s a certain sort of person who goes into criminal law over the others, and that’s the person who’s got a bit of a stronger social conscience,” (Jen, 712–715). Several described their wish to help people, “I did [this job] because I really care about what I do, I really really care about being able to defend people that can’t look after themselves,” (Max, 329–333). Others named feelings of empathy and care as crucial to the role, “if you’re not doing this job out of a sense of empathy then, (.) or at least with a sense of empathy, then why are you doing it?” (Ben 263–266). Jen described how as an advocate, one should be prepared to put in extra work for one’s clients:

“I think if you’re prepared as an advocate, or as a solicitor, representing someone who’s not well, who needs a bit more care, if you’re prepared to put the time in and take a bit of a beating from the court, I think that’s much better for the client in the long run.” (Jen, 243–246)

3.2.4 ILLUSION OF CONFIDENCE

Linked to their lack of training and guidance, and relative juniority, most of the participants described feeling underprepared and unconfident about working with clients with mental health needs. Many expressed worries and concern, e.g.:

“Interviewer: What was it that frightened you about that client?”

Jen: I felt like it was possibly beyond my competence [...] I didn’t know whether I could actually do a good enough job, with her in that state [...] Maybe frightened was the wrong word, I think it’s sort of anxiety, professional anxiety.” (Jen, 377 – 398)

Yet, several participants explained that it was a career where you needed to appear confident, e.g., “that’s part of the profession, that we don’t let someone see how little we might know,” (Ben, 91–92). All participants described that a strong relationship with the client was crucial to the case, and Ben felt that appearing confident was part of this.

Some participants said this confidence was important for winning the case, too, with Matt describing how seeming otherwise, “can give your opponent a sort of advantage [...] they’ll just steam roller you,” (706–708). Similarly, Ben said,

“In order to get anywhere you have to make other barristers think that you’re competent and a lot of how you can win things in court is just based on bluster and appearing to know you saying and making someone else think that they don’t know what they’re saying.” (132–137)

This extract also illustrates the importance of appearing competent in front of other barristers, a point raised by other participants. Admitting to a lack of confidence could have serious consequences for your career:

“Because you might genuinely not feel comfortable but [...] if there’s an adjournment for not a good reason, the solicitors might get wasted costs, they might never instruct you again, your practice will go down a little bit, and it’s, again, it’s not actually the worst thing in the world sometimes [...] but when you’re sort of, just coming into it, it can feel like it is the worst thing in the world.” (Matt, 637–646)

Similarly, Max described that in such a tough work environment, barristers were focused on survival, and to admit vulnerability would mean others felt you weren’t cut out for the job:

“I think that’s the survival atmosphere of, I’m coping, and I go home at night sometimes and feel like, you know, feel horrendous from my day’s work and if you can’t hack it, then you, you shouldn’t probably be doing this job.” (Max, 498–506)

3.2.5 CONFLICTING OBLIGATIONS

This subtheme is characterised by the barristers feeling stuck between opposing obligations: to the court or the client, to the defence or their overall welfare. Whilst attempting to act in their client’s best interests, due to the difficulties outlined above, they often felt unsure about what these were.

Many barristers were faced with a dilemma when clients did not give instructions:

“As a barrister you literally act on your instructions, and when you’ve got a client who can’t give you anything more sensible than, the Catholic Church are conspiring with the paedophiles I just (4) you’re pretty much left on your own.” (Jen, 365–388)

Tina felt more professional guidance should be given in this respect, feeling unclear about her obligations:

“I don’t think it’s made clear when you’re doing your bar training what exactly it is you’re supposed to do in that situation. Because you can’t take any instructions from that person so are [...] you given free rein to just do whatever you think is the best for that client? Or, is there some sort of limit to what you should be doing?” (Tina, 67–74)

Many participants described conflicting obligations to the court and to their client. If barristers felt their clients were too unwell to plead, but the client did not agree, the barristers could be left in a, “a bit of a no-man’s land,” (Matt, 216); between their obligation to follow the client’s instructions, and a duty of care. Joe described how in court, “sometimes everyone will use kind of coded language,” (107) and Jen similarly said, “you end up talking in riddles,” (186) or:

“You have to hope that they behave in such a mad way, as soon as you get into court, that you can then legitimately say that I have a real concern without having to raise it with them directly.” (Jen, 559 – 565)

In the above extract, Jen described this as, “the chicken’s way out” (563), illustrating a feeling shared by many participants: that there is often no comfortable solution to these dilemmas; elsewhere Jen describes this as, “you’re slightly damned if you do and damned if you don’t,” (128).

Several participants described an “impasse,” (Lee, 377) in this conflict between the duty to the court, and to their client,

“You have this kind of impasse which is completely illogical, completely irrational [...] after all it’s not your purpose to tell them what to do, and that comes up all the time, just blunt irrationality at like, a deep level.” (Joe, 205–211)

Participants described weighing up a range of issues to determine what might be in their client’s best interests, and described a tension between attempting to think about this more holistically, and presenting the most forceful defence:

“It’s very difficult for a lot, for a lot of lawyers to know what to do because without a strong feeling, you wonder whether you’re working against the interests of your own clients, and you’re damaging your relationship with them, by suggesting against their interests that they should go and see a doctor.” (Joe, 73–79)

In addition to the concerns about outcomes raised earlier, Joe questioned whether his specific input in the trial might be detrimental. He wondered whether presenting a forceful defence might further serve to entrench someone’s bizarre behaviour:

“Am I pretending that, that what they’re doing is okay or that they have a case to answer, because [the defendant] may well have thought, well Mr [Joe’s surname]’s argued this really forcefully so it is okay, whereas what he probably needed was more people telling him, you can’t do this, or, why are you doing this?”
(Joe, 928–934)

Two of the participants seemed to hold a different perspective to the other barristers. Jess seemed to be the least conflicted about her obligations; followed by Jen, who named anxieties but fundamentally felt clear that her primary duty as an advocate was to protect her clients. For Jen, the act of fighting for vulnerable clients confirmed her value as someone with a social conscience; whereas Jess’ behaviour was aligned with her the values she privileged, such as confidentiality. Jess’ lack of “professional anxiety” may also connect to the way she has chosen to manage the stress and distress of work in the MC.

3.3 SUMMARY OF THEMES

Broadly, participants conceptualised mental health from either a contextualised or medicalised position; but with the exception of Tina, were aware of and resisted paternalism. However, they expressed limits to their role in facilitating autonomy, weighing this against a duty to protect the public, and a duty of care to their clients. Most participants described distress at working in these systems, which could at times be overwhelming.

Most participants were well aware of issues in the CJS, and how these could pose particular disadvantages to those with mental health problems. Linked to their feelings of responsibility for these clients, participants did their best to mitigate the harm of these systems, and manage very high levels of distress and risk. One participant, Jess, held a notably different account on these themes. She expressed little “professional anxiety,” and rather than attempt to make up for the shortfalls of the wider system, instead worked within the role prescribed of her. Whilst it is possible that this may have led to worse outcomes for her clients, she expressed much less stress and distress; perhaps illustrating an adaptive response to the impossible task of mitigating the harm of the CJS.

4 DISCUSSION

Research findings are considered with respect to theory, followed by an evaluation of this research.

4.1 DISCUSSION OF THEMES AND LITERATURE

As an exploratory study, the research questions were necessarily broad:

How do barristers work with psychological distress throughout the Magistrates' Court process?

1. How do barristers construct mental health, and what experience do they have of working with clients who they perceive to have a mental health difficulty?
2. How do barristers defend clients who they perceive to have a mental health difficulty, and how do they work with their clients' associated distress?
3. How might a mental health difficulty influence the outcome of the court case, from the perspective of the defence barrister?

As stated in the introduction, the court process refers to the barristers' involvement in meeting the client shortly before the trial, how they are worked with and represented in court, and how outcomes may be influenced by perceived mental health difficulties. The title and the research questions were devised in reference to the distress of defendants. However, as the analysis has elucidated, the barristers' own distress is also an item of interest, and will be considered.

Due to this breadth and the limitations of the word count, points arising are addressed within an overall discussion of the themes, rather than structured by question. Broadly, research question one is addressed within "construction of mental health" and then throughout. For question two, strategic issues are mostly contained within "working with mental health difficulties," and managing distress within the aptly named, "working with clients' distress" section. Question three is considered from a systemic perspective in, "systematic disadvantage of those with mental health needs," with speculation about the influence of barristers' own actions outlined in "working with mental health difficulties." The considerable, worrying levels of distress expressed by barristers is discussed within "professional anxiety and barristers'

distress” and then further in “burnout.” Finally, ethical issues are considered as well as recommendations from this research.

4.1.1 CONSTRUCTION OF MENTAL HEALTH

Participants varied in what they considered to be a mental health problem. Some participants seemed to be talking about only very significant difficulties such as psychosis. These participants attributed stress and anxiety to the courtroom process itself. Others included a range of difficulties that included experiences of anxiety and depression, acknowledging that these might interact with the stress of the court case, but not be wholly attributed to it. The interview questions imposed the construct “mental health difficulty,” without explicitly inviting other conceptualisations of their clients’ experience, for example of “distress” or “emotional difficulties.” This may have influenced participants’ responses and is discussed further in the “evaluation of current research” section below, under, “the impact of interview questions.”

None of the participants described a criminalising perspective (immoral, deserve punishment, Peter & Schneider, 1992), which seems reasonable, given their purpose was to defend their clients. Instead, participants tended to be more committed to either a medicalising or contextualising account of their clients’ distress. Participants who occupied more of a medicalising position were inclined to construe their clients’ difficulties as an illness. As discussed in the introduction, a medicalising narrative is predominant in our culture and particularly in the CJS (Gerard, 1986, Leslie et al., 2007, Hall, Miraglia, & Li-Wen, 2011). This was reflected in the participants’ accounts that in the courtroom, distress needed to be legitimised by medical diagnosis.

Other participants appeared to speak from more of a contextualising position, conceptually similar to psychological formulation; and situated their clients’ difficulties within a psychosocial context (Johnstone, 2011). Perhaps these differing positions can be explained by their chronic exposure to both their clients’ social disadvantage, and the medicalising courtroom narrative. It should be noted that these constructs are only heuristically presented as a dichotomy; whilst all participants appeared to speak more from one position or the other, most expressed occasional views from

the other position. Dualism is generally an artefact of research, simplifying individuals' nuanced and heterogeneous beliefs (Kvale, 1992).; nonetheless, it is presented here as such in the interests of parsimony.

4.1.2 WORKING WITH CLIENTS' MENTAL HEALTH DIFFICULTIES

The analysis considered how barristers worked with their clients' mental health throughout the courtroom process, including how it was identified, used or not used as a defence strategy, and how associated distress was managed within the courtroom. Participants varied in the extent to which they actively used mental health as part of the defence, and allowed or restricted their clients' autonomy. Some participants felt strongly that Magistrates held prejudicial attitudes towards those with mental health difficulties and attempted to keep disclosures from the court, whilst others did not feel this was an issue. Several participants were ambivalent about assuming responsibility for their clients, and resisted paternalism; aware of the restrictive nature of hospital orders, they were careful not to seek treatment at any cost. One participant, unclear about her obligations, assumed responsibility for her clients and attempted to persuade them of their need for treatment, in a somewhat paternalistic manner.

Previous, realist research on lawyers related the construction of mental health to distinct typologies of defence strategy (Laberge & Morin, 2001). As this research comes from a critical realist epistemological position, it is not valid to make truth claims about how these constructs led the barristers to particular actions. However, the adoption of a medicalising or contextualising position did appear to limit, or open up, options for barristers in conversations with their client. It is speculated here that that adoption of one or other position may have led to different conversations, and therefore differing identification of mental health. Participants speaking from a contextualising position seemed to find it easier to elicit a disclosure of mental health than those adopting a more medicalised view of distress. Rather than masking their difficulties, as suggested by some of the participants, research suggests that nondisclosure is related to holding a non-medical view of distress (Irvine, 2011). Clients may have denied "mental health problems" as they simply did not understand

their difficulties as such; whereas they may have agreed they had stress or worry. One participant never asked her clients about mental health, and they never brought it up, potentially leading to worrying under-identification of needs in her clients. Perhaps by not having these conversations she protected her own psychological health, discussed further below in “context and mechanisms of role conflict.”

The potential for paternalism within the barrister-client relationship, and that mental health needs may not be identified, is troubling. Paternalism can be elicited from traditional models of psychiatry. Whilst aiming to improve the health and care of those with mental health difficulties, it may simultaneously subjugate their autonomy (Pelto-Piri, Engström, & Engström, 2013). Equally, completely neglecting to ask about mental health could deprive clients of a defence, impede engagement with the trial, prevent access to support for those who want it, and lead to more punitive sentencing. These are serious implications for defendants, potentially depriving them of a fundamental human right: the right to a fair trial (Sieghart, 1983).

Whilst diagnosis comes with its own problems, clients should be offered the opportunity to use these labels for their defence, if they feel the benefits are worth the cost. For example, should the client consent to having their difficulties constructed medically and receiving a diagnosis, it could be entered as mitigating evidence for sentencing, and in limited cases, offer a defence in its own right. However, this needs to be suggested from a position of autonomy, not paternalism; with barristers respecting the client’s right to make unwise decisions. This is a complex issue, but clients stand to lose if barristers are not able to have these discussions.

To name these issues is not an attempt to castigate these barristers, who had their client’s best interests at heart at all times, and lacked both training and guidance to meet their needs. Systemic changes are needed, so that barristers are made aware of both their professional responsibilities and their limits, and receive training to apply this in practice.

4.1.3 CONTEXT AND MECHANISMS OF ROLE CONFLICT

Szasz argued that it was more honest to label social deviancy as such, rather than mental illness, and that the state should restrict its powers of control to the law (Ennis & Szasz, 1972, Pelto-Piri et al., 2013). As some participants identified, running the trial (rather than using fitness to plead proceedings) afforded their clients more rights than risking the indeterminate restriction imposed by a hospital order. To a great extent, Szasz' ideals are indeed being played out in the MC, with the great majority of clients undiagnosed (Department of Health, 2009), and instead treated as criminals. Yet most participants regarded this process of criminalisation as fundamentally unethical, punishing social disadvantage, and providing no benefit to society.

Participants reported conflicted feelings about their place within this flawed system. An inability to meet the contradictory demands of both the court and wider CJS, and their client, may have led to a state of role conflict, where employees are pulled between multiple incompatible roles and which is associated with distress (Maslach, 2003). Self-perception theory offers an explanation of a psychological mechanism between behaviour, role conflict and distress, and suggests that we judge our sense of self by our actions (Bem, 1972). If we deem our behaviour as conflicting with our sense of self, we feel distressed. According to this theory, participants who felt they were acting against their values would have been more likely to judge themselves negatively, and feel distressed; with those unclear about the right action to take left feeling similarly unclear about their sense of self. This was supported by the data, with participants who expressed more conflicting views also likely to express considerable distress.

When forced to act contrary to their values, for self-preservation individuals often resort to changing their beliefs to match their behaviour; termed cognitive dissonance (Angermeyer & Matschinger, 2003). Changing one's beliefs protects one's self-image, and resolves the associated sense of internal conflict. Yet, despite consequences to their psychological health, most participants did not seem to employ cognitive dissonance, and were acutely aware of their sense of conflict. This

may be partially explained by their professional training. A barrister's role involves considering multiple perspectives, and all sides of an argument, so that they can present the best defence. Their professional capacity to hold ambivalence, whilst fundamental to their work, may mean they experience greater internal conflict. The emotional implications of this are discussed below.

4.1.4 PROFESSIONAL ANXIETY AND BARRISTERS' DISTRESS

In addition to managing the long hours and stressful environment of the MC whilst inexperienced and junior, barristers have to manage the high emotional demands of working with vulnerable clients. Their resources to meet the emotional needs of these clients were diminished by the lack of professional training and guidance available to them. Participants described considerable role conflict, attempting to offer more support than they could emotionally manage, and additionally working within a system with which most of them disagreed, and considered deeply flawed. Most reported significant distress, particularly at the beginning of their career when more junior. Whilst some practical support was available, emotional support was not.

The occupational model of stress, which posits that when job demands are high and the resources are low, role strain emerges; suggests that barristers are likely to feel stressed and distressed by this working environment (Bergin & Jimmieson, 2013). Participants described deeply held feelings of responsibility for their clients, working very hard to meet their needs. High role conflict and emotional demands are the strongest predictors of future psychological distress (Johannessen, Tynes, & Sterud, 2013), with the risk of role strain greatest for those doing their utmost to meet the emotional demands of their clients (Maslach, 2003). Consistent with this theory, participants described a high level of distress; and several described feelings of exhaustion, a component of burnout (discussed further below). Working against one's values, role conflict, high workload, and insufficient control over resources are all risk factors for burnout, placing barristers at a high risk (Maslach, 2003).

Their distress may have been mediated by the perceived professional inaccessibility of, or unacceptability of seeking, emotional support. This may be a consequence of their prolonged period of professional socialisation, and its consequent signifiers that

emotional suppression is necessary (Harris, 2002). The belief that suppressing emotion is an inherent aspect of professionalism is suggested by the idea described in theme two: that seeking support meant you were not cut out from the job; and also in theme one: that distress was something you were meant to just get used to. Repression of emotion independently increases exhaustion, and consequent burnout (Lazányi, 2010). Furthermore, an inability to share their emotional lives with peers deprives barristers of an important coping strategy and may increase distress, as the relationship between role strain and burnout is mediated by a lack of social support and community resources (Maslach, 2003). However, without further research with barristers, this is merely speculation.

4.1.5 BURNOUT

Whilst the research did not specifically set out to measure this, many participants reported experiences akin to burnout, such as exhaustion. Burnout is a state of psychological stress, and has been conceptualised as a combination of emotional exhaustion, depersonalisation, and lowering of personal accountability and motivation (Maslach, 2003). For the reasons outlined above, working with clients with mental health needs may substantially increase the risk of burnout for barristers. But alongside their own emotional health, barristers risk harm to their clients.

Burnout may lead to poorer decision-making due to depleted cognitive resources (Fischman, 2008). In an attempt to reduce the emotional burden upon them, individuals who are burnt out may begin treating others as objects rather than people (Maslach, 2003). This is “depersonalisation,” and was identified by one participant in theme one, who said the cost of chronic over demand on resources may be that one no longer cares. This feeling of depersonalisation, and the additional effects of lowered personal accountability and motivation, may account for the unethical behaviour reported by one participant in theme one. He described that under immense financial pressures, barristers were motivated to work unethically, perhaps unlawfully. General strain theory predicts that strain is produced by role conflict, overload, and financial concerns; and that where there is no legitimate opportunity to reduce strain, crime will result (Langton & Piquero, 2007). This relationship is

mediated by low social support (Langton & Piquero, 2007), which was reported by these participants as a consequence of their professional socialisation; and by the erosion of ideals and depersonalisation that is associated with burnout (Shahzad & Mahmood, 2012). Under such strain, barristers may resort to working unethically; motivated by finances, rather than the best interests of their clients.

Participants reported that representing clients with mental health needs required time and work that they would be unlikely to be compensated for. Either as a direct consequence of their mental health difficulties, or because of factors associated with related socio-economic deprivation and exclusion, these clients may be less likely to be less able to advocate for themselves (Durkan, 2009). As a group, clients with mental health difficulties are therefore at a high risk of receiving unethical practice from barristers, as a consequence of burnout.

4.1.6 WORKING WITH CLIENTS' DISTRESS

As outlined above, participants described the significant emotional impact of dealing with distress. They clearly identified a lack of resources to manage this, with almost all desiring training on the best way to engage with, and manage these clients. Many were left feeling “like a social worker,”¹⁰ juggling multiple roles, but without supervision or support to prevent them feeling overly responsible or to process their distress, contributing to the role conflict outlined earlier.

Interestingly, despite feeling unskilled at managing their clients' distress, the responses from most participants in this study indicated a high level of emotional astuteness and sensitivity. This may reflect a sampling bias (discussed later), but may also be related to the disempowering effects of a medicalised narrative of distress. Agendas such as, “mental health literacy” acknowledge that public beliefs about distress differ from psychiatric constructions, and privileging expert over lay perspectives, seek to educate and inform the public of a medical model (Jorm, 2000). This has been described as the domination of medical authority. Emotional distress is removed from the public realm, and put on a plane where only medical

^P(Lee, 71), as quoted on pg. 53

experts can legitimately discuss it (Peter & Schneider, 1992). This may have influenced one participant's account of feeling disempowered, and that mental health should be left to "experts." Barristers may be empowered by access to a psychological account of a spectrum of distress, which demands interpersonal, rather than expert, skills.

Participants identified that their clients with mental health needs could have significant communication issues, which could again infringe upon their right to a fair trial. Unlike the Crown court, intermediaries are not provided for defendants with communication difficulties, thus many participants put in extra work to make sure that their client understood the trial¹¹. Other difficulties reported by the participants included clients acquiescing, difficulties processing large amounts of information, and apparently illogical or confusing statements. This led to participants finding it difficult to ensure that their client fully understood the case, necessary for the participant to establish before they could take instructions (i.e. a plea of guilty or not guilty). It also meant some clients had trouble understanding the trial proceedings as they happened. This reflects research that found a high level of speech and language difficulties in young offenders ((Bryan, 2004), there is little research with adults). Barristers are not given any training in identifying communication difficulties, which is concerning, as if these are missed clients may not understand what is happening in court; or more worryingly, simply agree to whatever the barrister says.

Barristers additionally described various difficulties in engaging clients with mental health difficulties. This included significant difficulties in obtaining instructions when their client was very distressed. For example, the barrister might need to present the client with considerable information on the evidence against them, which the client might struggle to process. Participants described the most unusual behaviour as the most difficult to work with, perhaps by virtue of its very unusualness, and their inexperience in managing this. However, these clients are likely to come under the diagnostic label of psychosis or schizophrenia, diagnoses often associated with public attitudes of fear, unpredictability and dangerousness (Angermeyer &

¹¹ N.B. Although they cannot provide equivalent support, e.g. sitting in the box.

Matschinger, 2003). Whether consciously or unconsciously, these societal narratives may have influenced participants' perceptions. Medical explanations have been shown to increase stigma (Angermeyer & Matschinger, 2003). Conversely, training in a psychological account of, for example, hearing voices, may help barristers to normalise these experiences, and to feel more confident about meeting their clients' needs.

A final consequence of the above is that these clients take additional time, which was not received sympathetically by the pressured MC; discussed further below.

4.1.7 SYSTEMATIC DISADVANTAGE OF THOSE WITH MENTAL HEALTH NEEDS

Multiple levels of systemic disadvantage may compromise the defence of people with mental health difficulties. This thesis has focussed on the barristers' experiences, rather than the system, and therefore this is presented only briefly. Participants explained defendants were particularly vulnerable to the time and financial pressures of the MC, and may: suffer undue pressure to enter a guilty plea; be offered no representation at all; face a trial that is unfairly biased towards a prosecution; or work with junior barristers who may not be sufficiently experienced to manage their case. Overwhelmingly, participants described ignorance and discrimination from court staff, and felt they needed comprehensive training in mental health.

Given the current interest in reform of the CJS for those with mental health needs (May, 2014), barristers are an obvious group to consult with, as they can offer a view from the inside. Yet the literature on diversion and liaison schemes rarely mention the defence, nor do working groups on reform (e.g. Durkan, Saunders, & Hazard, 2009). This research suggests barristers have important insights, and that their views should be taken into consideration in any reform.

4.1.8 ETHICAL ISSUES

Researchers are obliged to consider the ethical implications of their work (American Psychological Association, 1973), and this study raises multiple issues. One question concerns the extent to which barristers should be responsible for the

identification of mental health. I have suggested that due to the failures of the system to identify these needs, barristers make have a crucial role in doing so, and may potentially otherwise compromise the human rights of their clients. Yet they are already exceptionally overworked, feel overly-responsible and emotionally strained by the work, and are at potential risk of significant psychological harm in the form of burnout. Is it ethical to suggest they take on a further duty? Ultimately, this is not a question that can be answered by this thesis; it concerns the barristers' role within the CJS, which needs to be addressed by their professional body. What is certainly not ethical is the current situation, where barristers are left to fulfil this role by default, without training or support. Their voice is neglected in the vast majority of the literature on reform of the CJS for those with mental health needs, despite their crucial role in forming the client's defence. There is a pressing need for their work with clients with mental health difficulties to be recognised and taken seriously, as there may otherwise be significant implications for both the well-being of barristers, and their ability to provide effective defence for these clients.

Amongst the need for general mental health training, it is particularly alarming that these barristers did not appear to have sufficient training in risk assessment. Whilst knowing the procedure for overt disclosures, their comments suggest that they are unclear about what needs to be taken seriously, nor are they clear on how best to ask clients about risk. Furthermore, many participants expressed that they were sometimes at risk of violence or aggression, and again appeared to lack any training to deal with this. As discussed, detailed risk assessment itself is surely beyond the role of a barrister; but as a minimum, they should be provided with basic training aimed at keeping themselves safe, and when they should ask for a mental health assessment (e.g. veiled threats should always be followed up).

Where clients meet the criteria of unfit to plead (which is similar to not having capacity), some participants felt the best defence strategy was for them to assume responsibility for that client, and fight the case on their behalf. Participants made compelling arguments as to why this would be a preferable strategy, but this is ethically contentious. It involves one individual attempting to weigh up the best interests of that client and taking responsibility for that decision; and whilst it perhaps

seems obvious that by presenting the most forceful defence for the client's freedom would be in their best interests, there is a danger that other factors could be neglected (e.g. the inherent trauma of that person taking part in a trial). In healthcare, if someone lacks capacity, there are appropriate safeguards (e.g. best interest meetings), professionals are bound by the Mental Capacity Act (Department of Health, 2005), and there is considerable guidance on how to proceed (e.g. Jones, 2005). For barristers, this appears to be a huge grey area, with no guidance whatsoever. As some participants stated, it is unclear whether they have "free reign" to simply do what they think is best for that client; arguably, this is dangerous and potentially unethical. The professional body should make barristers' responsibilities clear in this circumstance.

4.1.9 RECOMMENDATIONS

In summary, this research makes the following recommendations.

The emotional health of barristers is severely neglected by both the research literature, the CJS, and the profession itself. Indeed, this was not a primary focus of this thesis¹², and their high risk for burnout was an unexpected finding (there is no other literature on the emotional well-being of UK barristers). Further research should investigate this as a primary focus. Their contact with very distressed and traumatised individuals, alongside reviewing horrific evidence, demands system level changes in the provision of emotional support. Alongside the implications for barristers, if these issues are not addressed, the financially motivated unethical behaviour discussed earlier may result in miscarriages of justice for their clients, with those who are vulnerable most likely to suffer.

Providing adequate training in mental health and risk assessment may also help barristers to feel better resourced, which may reduce their feelings of role strain, and consequent risk of burnout. Furthermore, it has been suggested here that not providing this training may mean mental health issues are not identified, potentially

¹² The literature on burnout is presented in the introduction for readability, but in fact was only researched after the data was analysed

compromising defendants' human rights to a fair trial. Equally when needs are identified and barristers, lacking guidance, assume responsibility for their clients; there is a risk of subjugation of autonomy and paternalism. Professional guidance is urgently needed as to barristers' responsibilities, and the limits to these. Training from a psychological perspective, rather than a medicalised perspective, may help barristers feel more confident in applying the interpersonal skills that they already have, and reduce any stigma or fear. The perspectives of the barristers in this study suggests that they would be open to such an approach.

Clinical psychology can offer an alternative perspective to the dichotomy of criminalisation and punishment versus medicalisation and paternalism. Whilst these paradigms lend themselves to individualised models of distress, a third option is to consider the economic, social, and family factors that might contribute to offending, and work on a more systemic level to reduce these. Furthermore, whilst not a particular focus of this research, much of what the participants identified as troubling were about systemic issues, such as cuts to legal aid. Clinical psychology arguably has a role in preventing distress, by tackling its root causes (Patel, 2003). This research suggests that established groups such as Psychologists Against Austerity (2015) should also encompass vulnerable people within the CJS, and attempt to address the levels of deprivation that may have contributed to their offending.

Finally, almost all participants highlighted that people with mental health difficulties were particularly vulnerable to courtroom prejudice and ignorance, and the time pressured MC. Advocating for their clients' needs was often very difficult in this context. Barristers' ideas should be taken into account by CJS reform groups, as the defence counsel's perspective is crucial. It is also recommended that these issues should be looked at in more depth by direct research on the MC itself, and other courtroom staff.

4.2 EVALUATION OF CURRENT RESEARCH

This chapter concludes with an evaluation of this research, including reference to specific criteria to evaluate research, a summary of limitations, and personal reflections on the research.

This research has been conducted from a critical realist epistemological position. From this perspective, knowledge is viewed as being profoundly shaped by subjective and cultural perspectives; with truth, knowledge and reality actively created by a communal construction and negotiation of meaning (Yardley, 1997). It follows that there is therefore no fixed criteria for establishing truth and knowledge (as this would constrain the possibilities of truth, or privilege the group whose truth criteria is deemed ““correct””), and therefore, a universal code of practice for evaluating qualitative research is inherently contradictory of its epistemological assumptions¹³.

However, in order for research to have any practical utility, its claims need to be legitimised somehow. Consequently, it is helpful to have an open-ended and flexible framework for the assessment of quality. This research has therefore been evaluated with reference to the criteria proposed by Yardley (2000): sensitivity to context, coherence, commitment, rigour, transparency, impact and importance. It is acknowledged that there are multiple ways to appraise qualitative research and in the spirit of pluralism the following does not represent a definitive assessment. However, its significant overlap with other proposed criteria¹⁴ suggests it may be a helpful perspective. Other theory has also been used to augment the evaluation where useful.

4.2.1 SENSITIVITY TO CONTEXT AND COHERENCE

These criteria are presented together, as in this research they are related. As a clinical psychology trainee, I had a good working knowledge of the constructs of mental health and distress that were used to inform interpretations; however, the discussion of burnout was an unexpected finding, and consequentially, this literature only informed a later stage of analysis; it therefore does not constitute a theme in its own right. All qualitative research inherently creates a constructed narrative (Yardley, 2000), and perhaps this “story” of burnout may have been more evident and

¹³. This is not to say that qualitative research cannot be conducted from a realist position, but a good proportion of it (including this study) is not.

¹⁴ e.g. Spencer, Ritchie, Lewis, & Dillon (2003) propose similarly: contribution, defensibility of design, credibility, and rigour).

coherent in the analysis, had I prior familiarity with this literature, and may have gone on to name this as a theme. It was instead drawn out within the discussion.

Nonetheless, this approach is consistent with the inductive form of research that had been planned (Braun & Clarke, 2006). All text has multiple levels of meaning, and the definitive reading of a text is ultimately the meaning made by the reader (Barthes & Heath, 1977). Arguably, then, to present an analysis that was not organised into theory-informed themes meant data was more true to itself, and allowed the theory links to instead be articulated transparently within the discussion.

Finally, the defining sociocultural context for participants was one of professional identity, which was interpreted as an important influence on findings of this research. However it is acknowledged that my understanding of this context has been reached second-hand through the process of consulting a somewhat scanty literature. A researcher with more familiarity with the legal world may have been able to offer different interpretations, based upon this context.

4.2.2 COMMITMENT

Commitment to the research can be demonstrated by the researcher's development of competence, skill, and immersion in the topic and data (Yardley, 2000). As a novice qualitative researcher, my skills in thematic analysis have increased exponentially. To this end I have attended teaching, read relevant literature, and thought critically about the research process. I gave myself sufficient time to immerse myself in the data, including several weeks of analysis; and I have attempted to engage with the topic from a variety of perspectives (for example, considering how staff construct deviant behaviour on the mental health ward where I work).

4.2.3 RIGOUR

Rigour refers to sample adequacy, completeness of the interpretation, and whether all variation and complexity has been sufficiently attended to (Yardley, 2000). A sample may be considered adequate if it has reached theoretical saturation, the point at which new data collection is not generating new insights (Oppong, 2013); in this study, this had to be balanced against limited time and resources. Whilst the

final participant's data corresponded to previous themes, there was one further item of interest that may have warranted further exploration¹⁵. Therefore, for the question of sample adequacy, saturation can only be tentatively claimed. Furthermore, one participant's data¹⁶ was markedly different from the others, which leads on to the next point: selection bias.

To consider selection bias in this case is to ask, were the people that self-selected for this study somehow different to the rest of the target population? Convenience sampling was used, which makes bias more likely (Oppong, 2013). To answer this question, one needs comparative population-level data which is notably absent for barristers, with a dearth of qualitative research in general, and none examining mental health. Thus, my hypothesis that the participants were perhaps better informed about, and more empathic towards, mental health (than the target population of barristers), is not verifiable as such. However, with one exception, all participants stated their interest in mental health which I interpreted as a motivation for taking part in the study; the remaining participant did not express this, (and from other comments, I inferred another motivation for participating). Potentially then, the sample predominantly reflects barristers already informed about mental health. Moreover, the only participant who did not identify mental health as an interest held markedly different views. Arguably, if barristers are generally poorly educated in mental health, perhaps her views are actually likely to be the most similar to the general population.

To return to sample adequacy, the question posed is whether these sampling errors are small enough not to nullify the conclusions of this study (Oppong, 2013). One can consider the second aspect of rigour, completeness of interpretation, in answering this question. The analysis has attempted to draw opposing perspectives into the analysis, considering "exceptions to the rule" as valuable data. To this end it could be argued that even if the target population may be less informed about mental

¹⁵ Specifically, he extended upon the theme of poor emotional support by stating there was stigma within the profession towards psychological distress, which had not been identified by any other participant.

¹⁶ Jess

health, conclusions can still be generalised about how they might understand and work with psychological distress. If they are less aware of mental health than this sample, this only amplifies the need for better training, although raises the question as to whether this would be so readily welcomed by the profession. Saturation is likely to be harder to reach with exploratory research, as previous literature cannot provide direction (on e.g. potentially interesting research questions). Thus this thesis should be considered a foundation for further research, and meets the criteria of rigour relative to the research question and aims: i.e. generating new insights about how barristers work with psychological distress.

Finally, “triangulation” with another source can be a useful way of validating data (Yardley, 2000). An obvious source for this study would have been to interview the barrister’s clients. This would address an apparent gap in the literature: the lived experience of people with mental health difficulties who have to negotiate the MC. The time and resource limited nature of this study precluded this, but research in this area would be a very helpful perspective, particularly given the current context of reform.

4.2.4 TRANSPARENCY

Reflexivity, below, is part of transparency as it allows the reader to understand how the researcher’s experiences and values, and the research methods, have impacted upon the study conclusions. Alongside detailing the methodology, extracts have been provided (Appendix B, H-L).

4.2.5 PERSONAL REFLEXIVITY: RESEARCHER AS INTERPRETER

Qualitative research is an inherently interpretive act. As it is impossible to separate the research from the researcher, this relationship must be made transparent, and reflected upon (Chamberlain, 2001).

I chose to do this research having spoken to a friend who had been newly appointed as a barrister, and was keen to tell me of his confusion about how to manage some very unusual clients, and his dilemmas about how to talk to them about mental health without having had any training. I was immediately interested in how he managed to have these conversations, and what the implications might be of feeling

poorly prepared for a job that demands so much interpersonally. The dearth of research spurred me on, and so it was that a casual conversation between friends became my thesis.

Whilst it was incredibly useful to have his contribution in the form of a pilot interview, I wonder whether his voice has perhaps framed the questions or content of the analysis. Equally, though, the early interviews inevitably shaped the later interviews, as I began to notice the same themes recurring. Such is the constructed nature of qualitative research from a non-realist position. On this point, unfortunately it is impossible to guide the reader about specific factors to take into account when reading this research, as it is too multifaceted and complex. I can at least reiterate Chamberlain's (2001) point above: the data was constructed between myself and the participants, on the basis of multiple levels of context, including each prior interview.

I wondered whether the participants identified similarities between themselves and I, as they were aware of my status as a doctoral student, and were themselves highly educated. I had also come to interview them about a subject that, for the most part, they also identified as an interest (mental health). This notion of similarity may have helped them to speak freely, as with that feeling comes an expectation of being met with understanding. However, it may also have led to unspoken assumptions of understanding that were not necessarily correct. For example, that we had a shared conception of psychological distress, or shared values of social justice. Fortunately for the research, the barristers made exceptional interview participants, and would clarify any question they were unsure of; hopefully minimising unintended misunderstandings. As one might expect for professional orators, they also seemed confident of their opinions. Due to their professional experience of presenting controversial opinions, and participants' expressions that this led to the development of a "thick skin," I felt they were perhaps also less likely to constrain their opinions, based on potential negative reactions from me.

As stated in the introduction, I attempted to interview participants as reflexively as possible. I therefore had to consider my own assumptions, as I have had very little contact with barristers previously. The very little research available to me cast a

somewhat negative light on the profession¹⁷ and I was admittedly surprised to find such a socially minded, compassionate group of individuals. Fortunately, they brought these values into discussion without prompting, so this was not lost in the analysis.

Finally, my own values have inevitably shaped the research. Having trained in clinical psychology, I do not relate to medicalised views on distress; and unsurprisingly, take the psychological perspective that distress is understandable, and rooted in a sociocultural context. Whilst I have attempted to consider other perspectives in my analysis and make these transparent, another researcher, with less critical views on diagnosis services, would perhaps have interpreted the data differently. For example, they may have been less likely to interpret paternalism (certainly, the literature on liaison and diversion schemes does not appear to consider this). Thus, the reader should be aware that I am primarily oriented towards values of respect and autonomy, which has likely guided my analysis, and influenced my interpretation

Personal reflexivity also relates to the impact of the work on the researcher. The reader is directed to the section Reflections (pg. 91) for some thoughts on this.

4.2.6 METHODOLOGICAL REFLEXIVITY

The research question, design and analysis will have had some influence over the study outcomes. My rudimentary understanding of the law (and its relation to mental health), and lack of previous literature to consult, meant the research was truly exploratory and informed by a broad research question. This has produced a number of outcomes; and whilst I hope that depth has not been overly sacrificed in the interests of breadth, future research could employ more targeted questions, and explore some of these issues further. The semi structured interviews felt very appropriate for an interviewer who did not know what she did not know, and participants who were very willing to talk (the impact of specific questions is

¹⁷ A particularly memorable quote in one qualitative study involved a male barrister referring to female clerks thus: “*They’re all slappers . . . [flirting] always works. A wink and a smile and chat go very long way!*” (Harris, 2002)

discussed below). However, quantitative methodologies might be usefully employed in the future, to get more of a sense of the whole of the target population. Finally, thematic analysis allowed the collation and interpretation of a number of themes in the data. Grounded theory might offer a useful alternative analytical model, as it would allow e.g. theory of the barristers' legal defence strategy to be developed (Willig, 2013).

4.2.7 THE IMPACT OF INTERVIEW QUESTIONS: THE TRAP OF LANGUAGE

This research set out to explore how barristers explain and construct psychological distress, in a way that was as value free as possible. The title and information sheet for the study used the term, "psychological distress," as it felt most concordant with my conceptualisations of distress as a continuum, and away from the medicalised language of, "mental health." However, in constructing the interview schedule, a pilot interview was held, and it seemed that this terminology was confusing to the participant, and made it more difficult to get an understanding of their experiences. It was therefore decided to use the term "mental health" for pragmatic reasons, as it apparently led quickly to a shared understanding, and was perhaps received in a less confronting way, as a lay term that was commonly understood.

However, a lay term in fact comes with a host of assumptions that have been created by the society in which it derived. As hinted above, "mental health" suggests a parity with physical health, an illness metaphor, of a categorical nature: you either have mental health difficulties, or you do not (Bentall, 2009). The interview questions therefore framed our discussions within this metaphor, which may have closed down alternative conceptualisations of distress (e.g. that it is a human reaction to adverse life circumstances, rather than an illness caused by biological mechanisms). It is possible that less medicalised narratives may have been elicited from the participants had I introduced different terminology. Equally, those sharing a more contextualised account of distress may have spoken more freely of this. Whilst I tried to be mindful of this when conducting the analysis, the reader should also take this into account when drawing their own conclusions.

4.2.8 IMPACT AND IMPORTANCE

As the first piece of qualitative research to investigate how barristers work with psychological distress, this thesis offers novel findings. Moreover, the findings have significant implications. As has been argued, many of those in the MC will be experiencing mental health issues; these individuals' ability to participate in the trial, and final outcome, is mediated by how barristers construct and identify distress, and how this informs their defence strategy. This thesis has suggested that these individuals' human right to a fair trial may be violated, due to the pressures upon, and inadequate training offered to, barristers. Furthermore, this research suggests that this combination of high workload, role conflict, and poor resources; alongside a professional socialisation that discourages emotional support, places barristers at high risk of burnout. It is hoped that this thesis stimulates further research, and can be used to advocate for emotional support for barristers, and the rights of their clients.

A note on the systemic issues identified by barristers (e.g. courtroom stigma). These are hugely significant for clients with mental health difficulties, but an investigation of this was not the focus of this research. Thus, whilst important, the impact of this finding (within the context of this thesis) is limited; further research is needed to investigate these issues, and effect change.

4.2.9 LIMITATIONS

The limitations of this research are summarised as follows:

My lack of familiarity with the legal world may have limited my ability to make contextual interpretations. Further research may consider working cross-professionally, consulting with legal professionals to inform the research.

A lack of previous research on the topic, my inexperience in law, and the broad research aims mean saturation may not have been reached. There is therefore potentially more to be discovered on the topic, and more research is needed.

Interview questions used the phrase "mental health," thus introducing a medical construct, which may have influenced responses, potentially eliciting more

medicalised perspectives. Furthermore, some questions were close-ended. Although this did not appear to limit the participants' responses, it is possible that open ended questions may have generated further data.

The "social desirability bias (Fisher, 1993)"¹⁸ may mean that unethical conduct by participants was not reported. It is my view that this was not the case for these participants, but should further research investigate this more fully, it would be advisable to consider means of addressing this, for example, anonymous online questionnaires.

Selection bias has potentially influenced this study, due to convenience sampling and self-selection of those who were most interested in the topic; however, not to the point of negating the claims made. It would be useful to use representative sampling in future research, or target barristers who are less informed about mental health.

Whilst the analysis suggests barristers have significant risk factors for developing burnout, this was a surprise finding, and interview questions were not directed at examining these experiences. Therefore, claims cannot be made about the prevalence or severity of barristers' psychological distress. Whilst professional socialisation is proposed as a mediating factor, this is an interpretation of collected data rather than the isolation and modelling of risk factors that would be better explored using quantitative research methods. Arguably, there is some benefit in not quantifying and individualising distress in this way, as the focus shifts from necessary systemic changes to the treatment of pathologised individuals¹⁹. However, evidence as to the incidence of barristers' distress would be helpful in advocating for change, and more research is needed to establish this.

¹⁸ The tendency for research participants to report socially desirable, rather than accurate, behaviours (Fisher, 1993).

¹⁹ For a nice example of this, Australian researchers found that extremely overworked lawyers went onto develop burnout; and proposed "over commitment" as a mediating variable, recommending that lawyers should monitor themselves for signs of over commitment, and seek help to prevent this - rather than advocate for systemic change to reduce workload (Bergin & Jimmieson, 2013).

Equally, whilst the systemic issues reported by participants are troubling (e.g. Magistrates holding stigmatised attitudes), this was not the focus of this research, and more research is needed before claims can be made about this.

This research did not include the voice of the clients themselves, which would have been useful for triangulation the data, and may provide an important perspective in future research.

4.3 REFLECTIONS

Whilst completing this research, I have been working on an inpatient psychiatric ward that uses sections and community treatment orders extensively. It is arguably the other side of the coin to that described by the study participants, with patients medicalised, rather than criminalised. Szasz' work (Ennis & Szasz, 1972) has provided a vocabulary for my deep-seated uneasiness at the level of coercion I witness, and am perhaps complicit in, by virtue of not opposing it. I agree that honesty and transparency is of paramount importance, and that labelling deviance as illness obscures whose best interests are really being acted upon; i.e., the public are being protected, rather than the patient "treated." Yet, the alternative process of criminalisation described by the participants, from my perspective, only offers more punishment to vulnerable people.

I have been left with more questions than answers. I am not hopeful that the current interest in CJS reform is likely to step much outside of this unsatisfactory mad or bad, medicalise or criminalise, paradigm. I am, at least, exceptionally careful in my own use of language with clients, and questioning of other professionals; neither of which serve to change much beyond my own sphere of influence. Ultimately, I would argue what is needed is a more just, and equal society. Both distress and criminal acts are rooted in social inequalities, and this research has confirmed my belief that psychologists have a role in advocating for a fairer society. We are also, consciously or otherwise, always part of systems that present sometimes unfathomable ethical dilemmas. I am grateful that I have at least reflected upon these, even if potential solutions remain distant.

4.4 SUMMARY

This exploratory study has produced a number of interesting findings. Participants constructed mental health in a variety of ways, apparently tending to occupy either more of a contextualising or medicalising position. Clients with mental health difficulties were particularly emotionally taxing, with participants unsure how to manage their distress. Ethical concerns were raised around the emotional well-being of barristers and their lack of training in mental health. Potentially the consequences of poor training included legal paternalism (subjugating the client's autonomy in an attempt to act in their "best interests"), or non-identification of mental health needs leading to the deprivation of defence options. These may represent unintended human right violations. Under extreme stress, it is possible that barristers were at high risk of burnout; affecting not only their own psychological health, but potentially leading to financially-driven unethical behaviour towards their clients, with those with mental health needs particularly vulnerable. Clients with mental health difficulties were also named as at particular risk of wider discrimination and inequalities in the CJS. Systemic changes, informed by clinical psychology, were recommended.

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APPENDIX A: INTERVIEW SCHEDULE

- 1) How long have you worked as a barrister and how many clients have you seen?
- 2) How many clients have you worked with who you've thought were experiencing mental health difficulties?
- 3) Have you had any specific training in mental health?
 - For example, as part of your training, have you been told how best to respond if someone seems to have a mental health condition?
- 4) What sort of training would you like to have in mental health (if any?)
- 5) What sort of things would you consider to be mental health conditions?
 - (Prompt if necessary) What about personality disorder?
- 6) How do you go about assessing fitness to plead?
- 7) If you suspect your client has mental health needs, how would you raise this with them?
- 8) To what extent do you think mental health difficulties lead to your clients being arrested?
- 9) How do you feel about the outcome of the court case for [the clients you mentioned earlier]?
 - Do you feel like you've made a difference?
 - How are you left feeling?

Extra prompt question if no specific examples are given (to follow question 8):

- 1) Could you give me an example of someone you've worked with?
 - What was your role?
 - What impact did their mental health have on your work?
 - Did you liaise with anyone else?

APPENDIX B: EXAMPLE OF INTERVIEW TRANSCRIPT

Int: and then so of those clients, how many do you think may have been experiencing some kind of mental health difficulty?

Max: it's really hard to say because it's a, a very stressful and pressured time, and often in the Magistrate's Court as well you tend to find people when they're at their most stressed because they erm they've only just been remanded in custody <mmhmm> probably the night before by the police, they're arrested that night before <yeah> they are then interviewed at the police station and put court after being charged, so people are at a very heightened <yeah> state of erm, what's the word I'm looking for, distress <mmhmm> because they're not used to the fact that they've just been effectively incarcerated <mmhmm> and been reminded into custody, erm so it's it's hard, I have to say, officially I think is a tiny percentage that had erm during the trial process or the court process, their mental health issue was part of the court process. I'd probably maybe say, under 10% <mmhmm> where it actually becomes an issue in either their trial sentence erm

Int: do you mean in, in respect of that would have been, erm in some way interfering with, with the process, or been submitted as some kind of evidence within that?

Max: yes, absolutely. So either erm, it plays a part in the trial because their mental health effects the /<yeah>/ offence that they've been charged with and how the court determines whether or not they're guilty <yeah> erm, or in terms of sentence they have such a severe mental health issue that there's erm, and actual intervention that is needed in the courts <mmhmm> in terms of the mental health treatments <mmhmm> beyond that I would say at least in my view, at least the next 40% also have experienced mental health, have some form of mental health problem <mmhmm> maybe not diagnosed, recognised mental health disorder <mmhmm> which is where the courts tend to draw the line <mmhmm> they tend to only intervene or accept evidence when there is a recognised, <mmhmm> diagnosed mental health disorder, so someone with ADHD or schizophrenia or autism, something like that where it's got a doctor who signed, sealed, stamped a report and says this guy has got a recognised mental health problem, is actually only about 10%, then the next 40%

<mmhmm> either through alcohol, drugs, stress, pressure, horrific circumstances that they live under <yeah> have got some sort of, when you talk to them, they have some recognisable problem <mmhmm> they're not quite right, but they're not diagnosed with anything <mmhmm> either because they don't want to be, or because I often find a lot of them have sort of personality issue <mmhmm> personality disorder, but not recognised. So it's somewhere in that spectrum <mmhmm>, but it's not, it's not enough for there to be intervention <mmhmm> or, or diagnosed so <mmhmm> in total at least half my clients, and then beyond that then it's, it's at least 50 to 60% that I think <okay> have got some sort of issue

Int: yeah yeah and you said that, that's erm for, for a much smaller percentage of these clients, about 10% erm it might come into the trial in some way, and one of the ways that it could be erm brought into the trial would be assessing their guilt, because of the nature of their mental health difficulty <yeah yeah> could you give me an example of that?

Max: of course erm, so there are certain crimes, it's called specific intent <mmhmm> so certain crimes can only be committed if they have <mmhmm> a specific intent which means that you can't do it by reckless, a reckless act, so for example a common assault <mmhmm> which is the most basic form of assault, can either be committed in a reckless way <mmhmm> i.e. they didn't mean to hurt the person, but the way they behaved would have been reasonably foreseeable that their actions would have caused harm to somebody else....(continued)

APPENDIX C: INFORMATION SHEET

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ



The Principal Investigator: Lynsey Kelly, Email: xxx, Tel: XX

Consent to participate in a Research Study, “How do Criminal Defence Barristers Work with Psychological Distress Throughout the Courtroom Process?”

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate a research study. The study is being conducted as part of my Professional Doctorate in Clinical Psychology at the University of East London.

Why am I being asked to take part?

We know that many defendants in the criminal justice system have some degree of psychological distress or mental health problem. There is not much research, however, on how criminal defence lawyers work with these individuals. This study aims to explore how lawyers work with defendants throughout the courtroom process. This will include: lawyers’ knowledge and experience of mental health, what happens during the trial, and what lawyers think about the verdicts and outcomes for these individuals.

I am inviting criminal defence barristers or solicitors who have worked in a Magistrates’ Court to take part in these interviews.

What will happen to me if I take part?

If you decide to participate in this study, I will meet with you for one interview, which will take between 45-60 minutes. This will be audio-recorded so that I can analyse the data afterwards. It will take place in a private room, which can either be at the university, at your place of work, or at your home. Alternatively they can take place over Skype. After the interview there will be a chance to discuss your experience and ask questions.

What are the risks and benefits of taking part?

I do not anticipate any particular risks or disadvantages to taking part in this research, beyond making the time to do so. Questions are not expected to be of a particularly upsetting or personal nature. However, should you find the process distressing, there will be time to debrief at the end of the interview. You can also talk confidentially to The Samaritans, on 08457 90 90 90.

I cannot offer you any specific compensation for taking part. Benefits of taking part of the study, however, include contributing to the understanding of people with mental health conditions in the courtroom process. By taking part you may help to improve services for these individuals.

What will happen to my data?

After the interview, the audio recording will be transferred onto a computer, and the recording on the Dictaphone will be destroyed. The recording will be transcribed into an anonymised electronic document. The computer holding the audio recording and the electronic transcripts will be password protected. The audio file will be kept until the end of the study (May 2015) and the electronic transcripts for a further three years (May 2018), after which they will be destroyed. The same process will apply for Skype interviews.

Where and when will the interviews take place?

The interview will take place at a time and place convenient to you, and is expected to last between 45-60 minutes. I can meet with you at University of East London, which is based in Stratford. If you prefer and you have a private room that we can use, I can meet with you at your place of work, or your home. I can also conduct interviews over Skype.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Should you withdraw, I reserve the right to use your anonymised data in the write-up of the study and any further analysis.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

What if I have any questions or concerns about how the study has been conducted?

Please contact the study's supervisor:

Lara Frumkin, School of Psychology, University of East London, Water Lane, London E15 4LZ

(Tel: 020 8223 4352, Email: L.frumkin@uel.ac.uk)

Or

Chair of the School of Psychology Research Ethics Sub-committee:

Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Thank you in anticipation.

Yours sincerely,

Lynsey Kelly, 26.06.14



UNIVERSITY OF EAST LONDON
Consent to participate in a research study

How do Criminal Defence Barristers Work with Psychological Distress Throughout the Courtroom Process?

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date:

APPENDIX E: ETHICAL APPROVAL

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: Lara Frumkin

ASSESSOR: Ashok Jansari

STUDENT: Lynsey Kelly

DATE (sent to assessor): 18/02/2014

Proposed research topic: How do Criminal Defence Barristers Work with Psychological Distress Throughout the Courtroom Process?

Course: Professional Doctorate in Clinical Psychology

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| 1. Will free and informed consent of participants be obtained? | YES |
| 2. If there is any deception is it justified? | N/A |
| 3. Will information obtained remain confidential? | YES |
| 4. Will participants be made aware of their right to withdraw at any time? | YES |
| 5. Will participants be adequately debriefed? | YES |
| 6. If this study involves observation does it respect participants' privacy? | NA |
| 7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically? | NA |
| 8. Is procedure that might cause distress to participants ethical? | NA |
| 9. If there are inducements to take part in the project is this ethical? | NA |
| 10. If there are any other ethical issues involved, are they a problem? | NA |

APPROVED

YES

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: AJ Date: 22nd February 2014

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.



School of Psychology Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology



The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853



*APPENDIX F: TRANSCRIPTION SCHEME, AND ADDITIONAL ALTERATIONS
MADE TO QUOTES*

(.) Pause

(2) Two second pause

[Word] Words inserted by researcher to aid understanding (e.g. [Barristers]
substituted for [We])

[...] Omitted Word

[inaudible] Inaudible section of transcript

[laughter] Laughter during the interview

<Words> Brief interruption by second speaker

/Words/ Overlapping talk

APPENDIX G: PHASES OF THEMATIC ANALYSIS

Table 3: Braun & Clarke's (2006, pp 35) Phases of Thematic Analysis

Phase	Description
1. Familiarising yourself with your data	Transcribing data (if necessary), reading and rereading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a "thematic map" of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis

APPENDIX H: EXAMPLE NOTES ON THEMES

(See next page for typed up version)

OUR STORY BEGINS

Pt 4

70- vulnerability of defence overlooked
- proper support not provided (a lawyer

{ 84 x falling to the lawyers)
fitness to plead = worse, so instead run trial w/ more care

lawyers making up for inadequacies of the MC's when dealing w/ distress

135 The unsayable / notes of disclosing to the court.

dilemma impossible dilemmas

↳ unfit to plead as not being at all useful as a defence strategy "you've basically folded"

- 172 court proceedings as damaging in own right.

222 fear.

237 dips fitting in to generalized legal training.

250 overwhelming sense of responsibility for un. clients.

278 unfairness

risk assessment - if + erratic might disclose to court

Barristers' safety

Mode of payment

452 Criminal lawyers as those w/ social conscience

social welfare / social work

Typed version of previous page:

Pt 4

70- Vulnerability of defence overlooked – proper support not provided (and therefore falling to the lawyer). Lawyers making up the the inadequacies of the MC when dealing with distress

84- Fitness to plead is worst [option], so instead run the trial with more care

135- The unsayable/ risks of disclosing to the court

Impossible dilemmas – unfit to plead as not being at all useful as a defence strategy, “you’ve basically folded”

172 – Court proceedings as damaging in their own right

237- Difficulties fitting in to generalised legal training

250- Overwhelming sense of responsibility for vulnerable clients

278- Unfairness

Risk assessment: if very erratic, might disclose to the court

Barrister’s safety

Lack of payment

452- Criminal lawyers as those with a social conscience. Joint role: welfare / social work

APPENDIX I: EXAMPLE CODING

1334: erm. Yeah, so, it is really difficult, I think there, there isn't
 1335: basically that much guidance <mmhmm mmhmm> about how
 1336: to deal with mental health clients who can't give you any
 1337: instructions.
 1338: Int: and how do you think your colleagues that don't, have less,
 1339: well no experience of mental health understand their
 1340: professional obligation in those situations?
 1341: Tina: [sighs] I don't know, I mean I think, I think most barristers
 1342: who are at the self-employed Bar, you know, whether they do
 1343: prosecution work or not, I think most of the time, when they do
 1344: go to court, they do want the client's best interests, so they do
 1345: do what they can. But I think, because of the lack of
 1346: knowledge, there a lot of things probably do get missed
 1347: <mmhmm> erm, and especially now there's, well at the
 1348: Magistrate's Court anyway, it's a lot of solicitors covering
 1349: cases <mmhmm> and they've got just a huge volume <mmm>
 1350: of work, so they don't, they don't have time to spend with
 1351: somebody who's got mental health issues <mmm> erm, so
 1352: now it's like, things just get processed <mmhmm> and
 1353: normally now if I get involved, it's somewhere down the line,
 1354: where I'm having to undo a lot of what's gone on before,
 1355: because nobody has actually picked up on it, or done what
 1356: should have been done <mmhmm> erm, so I think that's, that's
 1357: the problem <mmhmm> yeah, I think people who don't have
 1358: any awareness of it, things get missed <mmhmm> definitely,
 1359: so actually that's a good point, the training should extend to
 1360: solicitors as well <mmm> cos it's a lot of solicitors now
 1361: <mmhmm> who do Magistrate's Court work <mmhmm> yeah
 1362: Int: and does the, so if things get missed, what are the
 1363: implications for those clients, if if?
 1364: Tina: well it depends, really. I mean, it might be, so the worst
 1365: thing is obviously if someone just pleads guilty and then gets



Magnified codes:

barristers holding responsibility

act on best interests even if this overrides autonomy

time and targets pressure

time and targets pressure

to time pressure

Criminalisation

Systemic Issues May Compromise Defence

vulnerable to time and financial pressures

lack of training as a concern

impasse

impasse

Using Mental Health As a Defence

Ill Resourced

training

feeling responsible

Barrister occupy a similarly ambivalent position

dilemma about what to do

welfare officer, social worker

to make up for shortfalls of wider system

welfare officer, social worker (2)

welfare officer, social worker

Clash of Imprecise Diagnosis with the Precise Legal System

Ethical Dilemma

Recognition of a flawed system

paternalistic

Responsibility

Pressures

Professional Anxiety

APPENDIX J: FINAL LIST OF CODES

1. ability to seek advice makes manageable	30. barristers emotional distress
2. acquittal not necessarily a good outcome	32. barristers holding responsibility
3. act on best interests even if this overrides autonon	33. barristers likely to hold prejudice
4. act on instructions	34. barristers make the initial decision to refer
5. acting against one's own values	
6. Acting unethically due to financial pressures	35. barristers role - a good but fair outcome
7. advice offered, but not emotional support	36. barristers role – present the case in the form that
8. alone	37. barristers role – respect clients autonomy
9. always raise with them first	38. barristers role - to concentrate resources on the legal issues
10. anger is distress	39. barristers role to act on best interests
11. angry	40. barristers unable to take up services due to stigma
12. anxiety and depression can be equally serious	41. barristers use their common sense as a proxy for training
13. appropriate adult changes the relationship	42. barristers value other things more highly than being paid
14. as advocate, should be willing to put in extra work	43. barristers working outside their competence
15. as less severe than MH	44. barristers would not be the first person to notice
16. asking about past mental health issues if think is a problem	45. bearer of bad news
17. assess situation first	46. behaviour in court may undermine defence
18. assessment of costs and benefits	47. benefits of identifying MH
19. associated with anger	48. better to run trial than use FTP
20. assumes responsibility	49. bias against the defendant
21. assuming responsibility versus supporting autonon	50. broken
22. avoid disclosing MH as may bias magistrate	51. build relationship first
23. awareness of stigma	52. can be unFTP but not covered by MHA
24. Barrister occupy a similarly ambivalent position	53. can make adjustments
25. barristers	54. can't cope
26. barristers acting unethically for financial reasons	55. categorical model
27. barristers as holding some responsibility for people	56. CJS as perpetuating shame
28. barristers can undermine autonomy	57. CJS as proxy community care
29. Barristers' Distress	

58. CJS making people worse	88. dealing with aggression
59. Clash of Imprecise Diagnosis with the Precise Legal System	89. dealing with aggression as a female
60. clash of views on reality	90. dealing with distress
61. client is likely to be very distressed	91. dealing with multiple people
62. clients may not understand	92. defendants vulnerability overlooked
63. clients may not wish to disclose MH	93. demonstrates a lack of faith in client
64. clients wishing to talk about their MH	94. despair
65. coded language	95. despondency
66. concerns about training	96. diagnosis as imprecise
67. conflict between obligation to client & court	97. diagnosis as diagnosis, not reifying
68. conflicting feelings	98. diagnosis as impressionistic
69. conflicting feelings (2)	99. diagnosis as pivotal, reifying
70. consequences of diagnosis	100. diagnosis needed to be recognised by the court
71. consideration of defendants' welfare detracts from the legal issues	101. diagnosis required for provision of support
72. consideration of impact of being antisocial on wide	102. diff to distinguish from LD
73. considers consequences of diagnosis	103. different view on reality as most concerning
74. considers running trial rather than using FTP as breaking rules	104. difficult decisions by court
75. constructions of mental health	105. difficult gaining instructions
76. coping	106. difficult if did not have criminal pupillage
77. costs	107. difficulties in making causal links for MH
78. court generally not prejudicial or stigmatising	108. difficulties managing disruptive behaviour
79. court staff also have a difficult job	109. difficulties with fitness to plead
80. courtroom & cjs prejudice & ignorance	110. difficulties working with client who is withdrawing
81. courtroom not having relevant information on MH	111. difficulty of the job not recognised by court
82. criminal responsibility and culpability	112. dignity
83. Criminalisation	113. dilemma about what to do
84. criminalisation associated with social disadvantage	114. directly suggest they may need to see a doctor
85. culture of disbelief	115. disempowered
86. damage to defence	116. district judges are better
87. damned if you do damned if you don't	117. distress in court

118. distress is a normal reaction to the stress of the	148. feeling responsible
119. distress not recognised by professional body	149. feeling sad when client disappointed despite best efforts
120. distress of the trial may be magnified by MH issue:	150. feeling sorry for
121. does MH or crime come first	151. feeling unsure
122. doesn't consider costs	152. feels confident to deal with MH
123. doing the job out of empathy	153. feels it is their responsibility to look out for MH
124. don't know what to do	154. financial pressure
125. double bind	155. for a first appearance, go to Crown Court, or enter not guilty
126. double bind (2)	156. formal support should be provided for traumatic cases
127. duty of care beyond trial	157. forms of mental health
128. duty of care to public	158. frames as non-expert yet takes expert position
129. easier to get support for the most obvious issues	159. frames discussion in legal & process terms rather than human
130. emotional resources	160. frames distress as anger
131. end up with no representation at all	161. ftp as discriminatory
132. engagement and the relationship	162. gentle exploration as direct q is risky
133. engagement with MHS is positive	163. get to court late
134. equates MH to illness and disability	164. giving instructions
135. Ethical Dilemma	165. good outcomes
136. Ethical Dilemma (Associated) Ill Resourced	166. good outcomes only possible with huge amounts of work
137. ethics of working w risk if untrained	167. greater risk of not referring
138. exhausted	168. guide through process
139. expects could find out what to do from guidelines c	169. handle stress
140. extreme cases can provide a defence	170. has related social issues, not in a vacuum
141. facilitating participation	171. have related substance use issues
142. fear	172. haven't previously accessed due to social disadvantage
143. fear and concern	173. help is dependent upon observable behaviour, or diagnosis
144. fear of damaging relationship	174. helplessness
145. fear of violence	175. hope it is noticed by the court
146. feeling blamed	176. horror
147. feeling complicit	177. Hospital orders no necessary a good outcome

178. how it will impact on client, and thereby the barrister	208. knows best (c.f. paternalism)
179. how MH makes you particularly vulnerable	209. lack confidence
180. humanity is missing	210. lack of comprehension is frightening
181. ideally raise directly	211. lack of consideration of stigma, prejudice
182. identification of MH risks over diagnosis of client	212. lack of diagnosis makes you vulnerable
183. identification of MH risks professional relationship	213. lack of dignity and autonomy
184. identification of MH risks slowing down the trial	214. lack of expertise in MC
185. identification of MH risks slowing down the trial, and distressing the client	215. lack of logic
186. if MH denied, could raise indirectly	216. lack of money in Magistrate's Court
187. if not addressed, MH may prevent people from fully participating – in plea process	217. lack of options for court when sentencing
188. if substance misuse	218. lack of professional guidance as a concern
189. if systemic issues addressed it'd mitigate their dist	219. lack of support
190. Ill Resourced	220. lack of support for junior barristers
191. Illusion of Confidence	221. lack of training as a concern
192. impaired ability to cope	222. lack training or skills should therefore stick to legal issues only
193. impasse	223. lawyer may not be believed by court
194. implications	224. LD as childlike
195. implications of a lack of support – you stop caring	225. learning on the job
196. imprecision of dx reflected in barristers feeling of indecision	226. learning on the job instead of training
197. improvement in support	227. learning on the job more important than training
198. in the interests of the client	228. legal advisor important
199. inadequate support offered	229. length of experience
200. includes anxiety, stress, depression	230. less able to think through complex social issues
201. incremental criminalisation	231. less capable
202. influence of ill resourced systems	232. longer time efficiency overlook
203. inherent trauma of the trial	233. magistrates may hold prejudicial attitudes
204. intermediary not available in the MC	234. magistrates may be biased, can't just forget
205. inviting and respecting client's view	235. makes meaning out of MH experiences
206. Junior barristers may not secure the best outcome	236. manage client's distress
207. knowledge of MH gathered from personal life	237. managing abnormal behaviour

238. managing distress	268. MH means not cut out for the job
239. Managing impasses and suspiciousness	269. MH means you need looking after
240. many are untreated	270. MH not always taken into account when sentencing
241. may be criminally responsible but not culpable	271. MH or ASD as bad
242. may be punished unfairly	272. MH or LD as needing protection
243. may identify MH but instead handover to solicitor	273. MH overrepresented
244. may lack resources to raise MH with the client	274. MH used as mitigating factors for the sentencing
245. may not wish to disclose	275. mhs as social control
246. May prevent them fully engaging with the trial	276. mild or less obvious problems may provide no defence
247. may suffer undue stress	277. mild problems most likely to be overlooked
248. may work harder as junior barrister	278. miss appointments
249. MC less serious, but proportionately very important	279. Mitigating Harm and Managing Distress
250. medical model	280. morality
251. mental health as a problem	281. more severe or obvious problems May provide a defence
252. MH as causal in the arrest	282. more time
253. MH as pathological	283. need for a big change, recognition of MH
254. MH as risk factor for the offence, but not sole cause	284. need for community care
255. MH as serious	285. need for conviction to get services
256. MH as vulnerable	286. need for diversion
257. MH cases take up more time, energy	287. need supervision
258. MH clients different, need a diff outlook	288. need to admit a problem to receive support
259. MH defence requires a lot of work	289. need to appear competent to survive
260. MH defence requiring huge amounts of work	290. negative talk about legal aid
261. MH framed as a medical condition	291. negative talk about police
262. MH is something wrong with you	292. negative talk about solicitors
263. MH issues relate to type of offence	293. never been a problem
264. MH leading to difficulties in communication and understanding	294. nice quotes
265. MH makes you less culpable	295. no confidential environment
266. MH may be unhelpful to trial outcome	296. no one cares
267. MH may bias the trial	297. no training for fitness to plead

298.no training in MH	328.personality disorder as dangerous
299.no training means things are missed	329.personality disorder as untreatable
300.non expert	330.persuading client not to disclose MH
301.non medicalised view	331.pity
302.non-expert, therefore disempowered	332.police can be good if diagnosed
303.normalises	333.poor experiences of MH services
304.not a barristers role to diagnose	334.positioning self as non-expert
305.not considering negatives of ftp or disclosure	335.possibility of overusing protection
306.not everyone is prepared to put in the time to work intensive but low paying cases	336.potential for naming MH to improve relationship
307.not getting paid for work	337.potential signs of MH
308.not homogenous	338.prejudice as a reason not to disclose
309.not making a big deal out of it, awareness of stigma	339.preoccupied
310.not raising MH due to fear of violence	340.pressure on junior barristers
311.not stupid, just need different communication skills	341.Pressures
312.not their responsibility	342.pressures mean barristers have to reconsider what they can offer
313.not to get an acquittal at all costs	343.previous professional experience
314.not wishing to admit they hold responsibility	344.prison more aversive for those with MH
315.on engagement	345.problem with fused powers
316.on the edges of society	346.problematic if training led barristers to try and diagnose clients
317.on whether or not to raise MH, best approach	347.problems caused by barristers' colluding
318.other professionals need training	348.problems defining mental health
319.others don't know how to deal	349.problems with CJS outcome data
320.outcomes	350.problems with profession - being junior
321.outcomes in nobody's interest best interests	351.Professional Anxiety
322.overrepresented	352.Professional Anxiety (Associated) how MH makes you particularly vulnerable
323.paternalistic	353.proportion with mental health
324.people with LD acquiescing	354.prosecution hold stigmatised attitudes
325.people with MH I generally still fit to plead	355.prosecution's under use of public interest grounds
326.people with MH needing more time	356.protecting the relationship
327.person with MH viewed as object	357.psychopathy as mysterious

358. psychosis is not understandable and therefore frightening and difficult	388. services are more about temporary prevention of harm
359. psychotic experiences as most serious	389. sexual offenders will not change
360. punishment versus rehabilitation	390. should always investigate
361. purpose of the CJS	391. should be left to professionals
362. questioning of current MH dangerous	392. sick
363. raising directly has ended badly	393. slow down trial
364. raising via court if safety issues	394. social causes
365. rapport as crucial	395. social control function
366. rescinds responsibility by taking a non-expert, helpless position	396. social exclusion as causal in MH
367. Recognition of a flawed system	397. some distress is manageable, very abnormal behaviour
368. Recognition that MH may lead to difficulties participating	398. some with a social conscience
369. referrals can help with defence	399. sometimes make a difference
370. reification	400. specific successes
371. related to functioning	401. spectrum, contextualised perspective
372. relational	402. stigma
373. relational resources	403. stigma - appreciation of wider societal issues
374. respect for autonomy	404. stigma of being a defendant
375. Responsibility	405. stigma within community leading to nondisclosure
376. risk to relationship	406. stigma, discrimination of being a defendant
377. risks autonomy and engagement	407. Strategies used
378. risks client suffering prejudice	408. strategy – get through day as quickly as quickly as possible
379. risks of not identifying MH	409. stress and competence
380. role as an advocate - to emotionally support	410. stress of working very long hours
381. role as an advocate - to emotionally support, engage and form a good relationship	411. stress on barristers may lead to worse outcomes
382. sad	412. stressed, pressured
383. sees role as about engaging fully	413. struggling with emotional burden
384. sees role as to form a good relationship	414. substance use doesn't count
385. self-stigma	415. substance use is related
386. self-care	416. substances as causal in offence
387. sensitivity to the fact the question is out of context	417. substances as self-medication

418.support offered	448.training
419.support worker as a positive	449.training may be difficult to remember in practice
420.supports autonomy	450.training needed in prosecution to
421.suppressing clients wish to be saved	451.training would help barristers to look confident
422.survive emotionally by focusing solely on legal ma	452.trauma as causal of MH
423.suspended sentences may not be helpful	453.traumatised
424.suspiciousness can damage relationship	454.trial process more important than trial outcome
425.symptoms as manifest distress	455.tries to resist social worker role
426.symptoms viewed as ways of coping	456.tries to understand
427.Systemic Issues May Compromise Defence	457.trying to avoid upsetting client
428.systemic resources	458.trying to manage paranoid behaviour
429.take the flak on behalf of the client	459.types of mental health problems
430.testing their thinking	460.ultimately comes down to the law
431.the CJS as proxy community care	461.unable to get to court
432.the unsayable	462.unable to meet demands
433.there is a group that can't be treated	463.under stress from court
434.those with moderate problems may be in the most difficult position	464.underprepared
435.those with skills are leaving the profession	465.under resourced diversion services don't meet the need
436.time and targets pressure	466.understand client is fully as possible so can judge this
437.time pressure means MH overlooked	467.unfairness
438.time pressure stresses out client	468.unfamiliarity with personality disorders
439.to be better prepared for a flawed system	469.unfit to plead as undesirable
440.to establish trust	470.unpredictable
441.to financial pressures	471.unreality of the courtroom
442.to help	472.unstable
443.to help barristers manage emotional difficulties	473.unsure how MH training might fit in
444.to identify more mild issues	474.unsure if aggression MH
445.to make up for shortfalls of wider system	475.unsure of, couldn't identify
446.to reassure, on their side	476.unsure what to do as a junior barrister
447.to time pressure	477.use of endorsements

478. use of indirect questions	508. would like training to address engagement
479. use of specific intent as a defence	509. would seek advice if necessary re MH
480. Using Mental Health As a Defence	510. wouldn't ask about MH
481. violates privileged confidential relationship	511. you only get one chance in the MC
482. vulnerable to time and financial pressures	ASD: autistic spectrum disorder CJS: criminal justice system FTP: fitness to plead LD: learning disability MC, Mags: Magistrate's Court MH: mental health, MHS: mental health services,
483. want to talk about social issues, not case	
484. weighing up the wider social benefits	
485. welfare officer, social worker	
486. welfare officer, social worker (2)	
487. what caused MH	
488. what if don't give instructions	
489. where knowledge gathered from	
490. whilst maybe criminally responsible, defendants are also socially disadvantaged	
491. will generally follow advice	
492. willingness to engage in clients reality	
493. wish for CJS to help people	
494. wish for rehabilitation or community care that is not met	
495. wish for solicitors to have training	
496. wish for training	
497. wish for training around communication and understanding	
498. wish for training around diagnoses	
499. wish for training around when to refer	
500. wish for training on dealing with distress	
501. wish for training on professional obligations	
502. wish for training on vulnerability not MM	
503. wish to save or be saved	
504. Working Within A Flawed System	
505. worrying	
506. would be better if profession was not split from solicitors	
507. would like training	

APPENDIX K: EXAMPLE OF ORGANISATION OF CODES

Name	Sources	References
Professional Anxiety	8	499
Conflicting Obligations	8	117
Pressures	8	252
III Resourced	8	77
lack of support	5	32
ability to seek advice makes manageable	1	1
advice offered, but not emotional support	1	1
barristers unable to take up services due to stigma	2	2
MH means not cut out for the job	1	1
difficulty of the job not recognised by court	1	1
distress not recognised by professional body	2	4
formal support should be provided for traumatic case	1	1
implications of a lack of support - you stop caring	1	1
lack of support for junior barristers	3	5
may work harder as junior barrister	1	1
need to admit a problem to receive support	1	1
pressure on junior barristers	1	2
problems with profession - being junior	2	2
unsure what to do as a junior barrister	2	2
learning on the job	4	5
stressed, pressured	6	19
training	8	21
Illusion of Confidence	7	60
lack confidence	7	48
lack confidence	7	48
fear and concern	5	20

APPENDIX L: INITIAL THEMATIC MAP

